PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)**
☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Crysvita® (burosumab-twza)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product:
☐ Crysvita 10 mg/mL
☐ Crysvita 20 mg/mL
☐ Crysvita 30 mg/mL

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Date of next dose (if applicable): _____
Dose:_____ **Dose Frequency**:_____

Place of administration:
☐ Physician's office
☐ Outpatient infusion
Facility: _____ NPI:_____ Fax:_____
☐ Home infusion
Facility: _____ NPI:_____ Fax:_____

Billing:
☐ Physician to buy and bill
☐ Facility to buy and bill
☐ Specialty Pharmacy
Pharmacy:_____ NPI:_____ Fax:_____

ICD-10 Diagnosis code(s): _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Treatment of X-linked hypophosphatemia (XLH) in patients 6 months of age and older. Diagnosis must be confirmed by:
   - Genetic testing (PHEX-gene mutation), OR
   - Serum fibroblast growth factor-23 (FGF23) level > 30 pg/mL

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 06/2018
Last reviewed 01/2021

2. Treatment of FGF23-related hypophosphatemia in tumor-induced osteomalacia (TIO) associated with phosphaturic mesenchymal tumors that cannot be curatively resected or localized in patients 2 years of age and older.
3. Must have baseline serum phosphorus level below lower limit of laboratory reference range with current hypophosphatemia.
4. Must have clinical signs and symptoms of XLH (e.g. rickets, growth retardation, musculoskeletal pain, bone fractures, etc.).

When the above criteria is met, initial approval of Crysvita® will be for 12 months.

For continuation, patient must meet the following requirements:

1. The patient is compliant in taking the medication as scheduled
2. Must have experienced normalization of serum phosphate while on therapy (documentation of laboratory levels must be submitted to Priority Health)
3. Must have experience a positive clinical response to therapy (e.g. enhanced height velocity, improvement in skeletal deformities, reduction in bone fractures)

When the above continuation criteria is met, approval of Crysvita® will be granted for no more than 12 months.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ X-linked hypophosphatemia

Which of the following is provided to confirm the diagnosis (documentation must be submitted to Priority Health)?

☐ Genetic testing
☐ FGF23 serum level > 30 pg/mL
☐ Neither; Rationale for use:_____

_____

☐ Tumor-induced osteomalacia

☐ Other – the patient's condition is: _____

Rationale for use: _____

B. What is the patient's serum phosphate level?_____ (lab report will reference range must be submitted to Priority Health)

C. Documentation of clinical signs and symptoms of XLH/TIO must be submitted to Priority Health.

Request to continue a previously authorized approval
Priority Health Precertification Documentation

A. Has the patient been compliant with therapy?

☐ Yes
☐ *No; rationale for continued use:*_____

_____

B. Documentation of normalized serum phosphate levels must be submitted to Priority Health

C. Documentation of improved clinical outcomes must be submitted to Priority Health

Additional information

When approved, the amount of Crysvita® allowed is limited to the FDA-approved dose and frequency.

Dosing of Crysvita® should not be adjusted more frequently than every 4 weeks and must be administered by a healthcare professional.

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Last reviewed 01/2021