PriorityHealth

Medical 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.

Krystexxa® (pegloticase)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

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

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product: ☐ Krystexxa 8 mg/mL vial

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing 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 for an initial 3 months, the patient must meet all of the following requirements:

1. Must have chronic, treatment-failure gout (TFG)
2. Patient must have three or more flares in the last 18 months
3. Must first try allopurinol using a daily dose of 900 mg for 6 months (or probenecid or febuxostat if allopurinol is contraindicated) and be unable to maintain a serum uric acid level less than or equal to 6 mg/dL

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 03/2011
Last reviewed 01/2021

4. Patient must have gout tophus or gouty arthritis
5. Patient must not have: unstable angina, uncontrolled arrhythmia, non-compensated heart failure, uncontrolled blood pressure (a blood pressure higher than 150/95 mmHg), received an organ transplant, glucose-6-phosphate dehydrogenase deficiency, or a need to receive dialysis

For a 12-month continuation, patient must have met the following requirements:

1. After 3 months of Krystexxa therapy, the patient's serum uric acid level must remain at or below 6 mg/dL

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.

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Treatment-failure gout
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. What is the patient's most recent serum uric acid level? _____

C. How many gout flares has the patient had in the last 18 months? _____

D. Which of the following drugs has the patient tried? And for how long?

☐ allopurinol	Daily dose: _____	For how long? _____
☐ febuxostat	Daily dose: _____	For how long? _____
☐ probenecid	Daily dose: _____	For how long? _____

E. Which, if any, of the following does the patient have?

- ☐ Gout tophus
- ☐ Gouty arthritis
- ☐ Unstable angina
- ☐ Uncontrolled arrhythmia
- ☐ Non-compensated heart failure
- ☐ Uncontrolled blood pressure (a blood pressure high than 150/95 mmHg)
- ☐ History of an organ transplant
- ☐ Glucose-6-phosphate dehydrogenase (G6PD) deficiency

Request to continue a previously authorized approval
Priority Health Precertification Documentation

A. What is the patient's most recent serum uric acid level? _____

Additional information

NOTE: If approved, initial authorization will be for one dose every two weeks for three months. Continued authorization beyond three months will be granted in 12 month authorization periods for patients who respond to initial therapy (defined as a serum uric acid level less than or equal to 6 mg/dL at month 3 after starting Krystexxa).

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