

HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM

KRYSTEXXA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department at 801-213-1547.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 833-981-0212

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

| | | |
|----------------|--------------|-----------------|
| Date: | Member Name: | ID#: |
| DOB: | Gender: | Physician: |
| Office Phone: | Office Fax: | Office Contact: |
| Height/Weight: | HCPCS Code: | |

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: Krystexxa® (pegloticase)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section.

| Questions | Yes | No | Comments/Notes |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|-------------------------------------|
| 1. Is the prescribing provider a rheumatologist? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Does documentation show a diagnosis of chronic gout with hyperuricemia? | <input type="checkbox"/> | <input type="checkbox"/> | Please provide documentation |
| 3. Does documentation demonstrate one of the following: <ul style="list-style-type: none"> • 3 or more gout flares in the previous 18 months • 1 or more tophus • Presence of chronic gouty arthritis? | <input type="checkbox"/> | <input type="checkbox"/> | Please provide documentation |
| 4. Has the member undertaken lifestyle modifications, such as weight loss for obese individuals (weight control) or avoidance of, or limiting, alcohol consumption or dietary intake of meats and fish high in purine content? | <input type="checkbox"/> | <input type="checkbox"/> | Please provide documentation |
| 5. Does documentation show a baseline serum uric acid level > 8mg/dL? | <input type="checkbox"/> | <input type="checkbox"/> | Please provide documentation |
| 6. Has the member failed, or is contraindicated/intolerant to, at least a 6-month trial of maximum tolerated FDA-approved doses of allopurinol and febuxostat? | <input type="checkbox"/> | <input type="checkbox"/> | Please provide documentation |
| 7. For members with African American or Mediterranean ancestry, has the member been screened and found negative for G6PD deficiency? | <input type="checkbox"/> | <input type="checkbox"/> | Please provide documentation |
| 8. Will Krystexxa® be given in combination with weekly methotrexate 15 mg orally? | <input type="checkbox"/> | <input type="checkbox"/> | Please provide documentation |

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|-------------------------------------|
| Krystexxa® alone may only be used in patients for whom methotrexate is contraindicated or not clinically appropriate. | | | |
| REAUTHORIZATION | | | |
| 1. Is the request for reauthorization of therapy? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Does clinical documentation show an improvement or stabilization of the condition? | <input type="checkbox"/> | <input type="checkbox"/> | Please provide documentation |
| 3. Does documentation show a recent uric acid level of < 6 mg/dL? | <input type="checkbox"/> | <input type="checkbox"/> | Please provide documentation |
| What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc. | | | |
| Additional information: | | | |
| Physician Signature: | | | |

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HU-M029
 Origination Date: 01/01/2022
 Reviewed/Revised Date: 08/24/2022
 Next Review Date: 08/24/2023
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