HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
KRYSTEXXA®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142.

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

If you have prior authorization questions, please call for assistance: University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

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?	☐	☐	
2. Does documentation show a diagnosis of chronic gout with hyperuricemia?	☐	☐	**Please provide documentation**
3. Does documentation demonstrate one of the following: • 3 or more gout flares in the previous 18 months • 1 or more tophus • Presence of chronic gouty arthritis?	☐	☐	**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?	☐	☐	**Please provide documentation**
5. Does documentation show a baseline serum uric acid level > 8mg/dL?	☐	☐	**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?	☐	☐	**Please provide documentation**
7. For members with African American or Mediterranean ancestry, has the member been screened and found negative for G6PD deficiency?	☐	☐	**Please provide documentation**
8. Will Krystexxa be given in combination with weekly methotrexate 15 mg orally?	☐	☐	**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?	☐	☐	
2. Does clinical documentation show an improvement or stabilization of the condition?	☐	☐	**Please provide documentation**
3. Does documentation show a recent uric acid level of < 6 mg/dL?	☐	☐	**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:

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Policy: PHARM-M029
Origination Date: 08/13/2022
Reviewed/Revised Date: 08/24/2022
Next Review Date: 08/24/2023
Current Effective Date: 09/01/2022