PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Krystexxa (pegloticase)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is this drug being prescribed for (pick one)?

☐ Chronic refractory gout with hyperuricemia ☐ Other (please specify)

Q2. Please provide ICD code(s) for diagnosis.

Q3. Is the patient a new start?

☐ Yes ☐ No

Q4. Does the patient have any of the following?

☐ Two or more gout attacks in the past 12 months
☐ Serum uric acid concentration above 5 mg/dL despite maximized prior therapy
☐ Serum uric acid concentrations at or above 6 mg/dL despite maximized prior therapy
☐ Tophaceous gout with presence on the hands, evidence of bone damage on x-ray, or significantly impacting quality of life

Q5. Will Krystexxa be used in combination with NSAIDS or colchicine for the first 6 months?

☐ Yes ☐ No

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Q6. Does the patient have failure of an adequate trial of, clinically significant intolerance or contraindication to the following? Please specify all that apply.

- ☐ Allopurinol 800 mg
- ☐ Uloric (febuxostat) 120 mg
- ☐ Other (please specify)

Q7. Will use of Krystexxa be limited to 8 mg (1 mL) per 14 days?

☐ Yes ☐ No

Q8. Does the patient have a contraindication to Krystexxa therapy (e.g. G6PD deficiency)?

☐ Yes ☐ No

Q9. If for continuation, does the patient have improvement in frequency and severity of attacks? Please submit documentation

☐ Yes ☐ No

Q10. If for continuation, does the patient have serum uric acid concentrations prior to infusion are consistently less than 6 mg/d? Please submit documentation

☐ Yes ☐ No

Q11. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

- ☐ Pharmacy
- ☐ Individual prescriber
- ☐ Provider or specialty group
- ☐ Facility
- ☐ Other (please specify)

Q12. Provide name and NPI of the billing entity

Q13. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q14. Additional Comments

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Prescriber Signature _____ Date _____

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.