



Crysvita

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the member identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: Same as Referring Provider Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____ *kg*

Patient Height: _____ *cm*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

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Site of Service Questions:

- A. Where will this drug be administered?
- | | |
|---|---|
| <input type="checkbox"/> Ambulatory surgical, <i>skip to Clinical Questions</i> | <input type="checkbox"/> Home infusion, <i>skip to Clinical Questions</i> |
| <input type="checkbox"/> Off-campus Outpatient Hospital | <input type="checkbox"/> On-campus Outpatient Hospital |
| <input type="checkbox"/> Physician office, <i>skip to Clinical Questions</i> | <input type="checkbox"/> Pharmacy, <i>skip to Clinical Questions</i> |
- B. Is this request to continue previously established treatment with the requested medication?
- Yes This is a continuation of an existing treatment.
- No This is a new therapy request (patient has not received requested medication in the last 6 months).
skip to Clinical Criteria Questions
- C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids or other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? **ACTION REQUIRED: Attach supporting clinical documentation.**
- Yes, *skip to Clinical Criteria Questions* No
- D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment? **ACTION REQUIRED: Attach supporting clinical documentation.** Yes, *skip to Clinical Criteria Questions* No
- E. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? **ACTION REQUIRED: Attach supporting clinical documentation.** Yes No

Criteria Questions:

1. What is the diagnosis?
- X-linked hypophosphatemia (XLH)
- FGF23-related hypophosphatemia in tumor induced osteomalacia (TIO)
- Other, please specify _____
2. What is the ICD-10 code? _____
3. Is the request for continuation of therapy with the requested medication? Yes No *If No, skip to diagnosis specific section*
4. Is the patient currently receiving the requested medication through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to diagnosis specific section.* Yes No Unknown
5. Is the patient experiencing benefit from therapy with the requested medication as evidenced by disease stability or disease improvement (e.g., increase or normalization in serum phosphate, improvement in bone and joint pain, reduction in fractures, improvement in skeletal deformities)? **ACTION REQUIRED: If yes, please submit documentation (e.g., chart notes, lab test results)** Yes No
6. Will the supporting documentation be included with this request? Yes No *No further questions.*

Complete the following section based on the patient's diagnosis, if applicable.

Section A: X-linked hypophosphatemia (XLH)

7. Does the patient have a known PHEX (phosphate regulating gene with homology to endopeptidases located on the X chromosome) mutation confirmed by genetic testing? **ACTION REQUIRED: If Yes, please submit genetic test results.** *If Yes, skip to #10* Yes No
8. Was a known PHEX (phosphate regulating gene with homology to endopeptidases located on the X chromosome) mutation confirmed by genetic testing in a directly related family member with appropriate X-linked inheritance?

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ACTION REQUIRED: If Yes, please submit genetic test results. If Yes, skip to #10 Yes No

9. Is the patient's serum fibroblast growth factor 23 (FGF23) level above the upper limit of normal or abnormal for the assay? **ACTION REQUIRED: If Yes, please submit laboratory test results.** Yes No Unknown
10. Does the patient have radiographic evidence of rickets or other bone disease attributed to XLH? **ACTION REQUIRED: If yes, please submit radiographic evidence.** Yes No
11. Will the supporting documentation be included with this request? Yes No

Section B: FGF23-related hypophosphatemia in tumor induced osteomalacia (TIO)

12. Is the patient's disease associated with phosphaturic mesenchymal tumors that cannot be curatively resected or localized? Yes No
13. Is the patient's diagnosis confirmed by ALL of the following? **ACTION REQUIRED: If yes, please submit corresponding laboratory documentation.** Yes No
- FGF23 level is above the upper limit of normal or abnormal for the assay
 - Fasting serum phosphorus levels are less than 2.5 mg/dL
 - Ratio of renal tubular maximum reabsorption rate of phosphate to glomerular filtration rate (TmP/GFR) is less than 2.5 mg/dL
14. Will the supporting documentation be included with this request? Yes No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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