Krystexxa

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient 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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

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

Site of Service Questions:

A. Where will this drug be administered?
- ❑ Ambulatory surgical, *skip to Clinical Questions*
- ❑ Home infusion, *skip to Clinical Questions*
- ❑ Off-campus Outpatient Hospital
- ❑ On-campus Outpatient Hospital
- ❑ Physician office, *skip to Clinical Questions*
- ❑ Pharmacy, *skip to Clinical Questions*

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, other pre-medications or slowing of the infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, Attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Does the patient have laboratory confirmed anti-pegloticase antibodies? ***ACTION REQUIRED: If Yes, Attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. 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: If Yes, Attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, Attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. 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 patient's diagnosis?
   - ❑ Chronic gout
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Will the requested drug be used concomitantly with oral urate-lowering therapies (e.g., allopurinol, Uloric [febuxostat])? ❑ Yes ❑ No
4. Has the patient had at least 2 gout flares per year that were inadequately controlled by colchicine or NSAIDs at the time of initiation of treatment with the requested drug? *If Yes, skip to #6* ❑ Yes ❑ No
5. Has the patient had at least 1 gout tophus or gouty arthritis at the time of initiation of treatment with the requested drug? ❑ Yes ❑ No
6. Has the patient had an inadequate response to at least a 3 month trial of allopurinol at the medically appropriate maximum dose? *If Yes, skip to #10* ❑ Yes ❑ No
7. Does the patient have a clinical reason for not completing at least a 3 month trial of allopurinol at the medically appropriate maximum dose (e.g., severe allergic reaction, intolerance, toxicity, significant drug interaction, severe renal dysfunction)? *If Yes, skip to #10* ❑ Yes ❑ No
8. Has patient had an inadequate response to at least a 3 month trial of Uloric (febuxostat) at the medically appropriate maximum dose? *If Yes, skip to #10* ❑ Yes ❑ No

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9. Does the patient have a clinical reason for not completing at least a 3 month trial of Uloric (febuxostat) at the medically appropriate maximum dose (e.g., severe allergic reaction, intolerance, toxicity, significant drug interaction, end stage renal impairment, history of CVD, new CV event)? ❑ Yes ❑ No

10. Has patient had an inadequate response to at least a 3 month trial of probenecid [alone or in combination with allopurinol or Uloric (febuxostat)] at the medically appropriate maximum dose?
If Yes, skip to #12 ❑ Yes ❑ No

11. Does the patient have a clinical reason for not completing at least a 3 month trial of probenecid at the medically appropriate maximum dose (e.g., severe allergic reaction, intolerance, toxicity, significant drug interaction, known blood dyscrasias, uric acid kidney stones, renal insufficiency)? ❑ Yes ❑ No

12. Is this a request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, no further questions*

13. Has the patient had two consecutive uric acid levels above 6 mg/dL since starting the requested drug?
❑ Yes ❑ No

14. Is the patient experiencing benefit from therapy (e.g., serum uric acid levels < 6 mg/dl, reduction of tophi, reduction of symptoms and/or flares)? ***ACTION REQUIRED: If 'Yes', please attach chart notes, lab test results or medical records documenting a benefit from therapy (e.g., serum uric acid levels < 6 mg/dl, reduction of tophi, reduction of symptoms and/or flares).*** ❑ 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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