

# OPTIMA HEALTH FAMILY CARE

## (MEDICAID)

### PHARMACY/MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST\*

**Directions:** The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-844-723-2094.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process.**

**Drug Requested:**      **Krystexxa™** (pegloticase) **(J-2507) (Medical)**

**DRUG INFORMATION:** Complete information below or authorization will be delayed.

**Drug Form/Strength/Quantity:** \_\_\_\_\_

**Dosing Schedule:** \_\_\_\_\_ **Length of Therapy:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **ICD Code:** \_\_\_\_\_

**CLINICAL CRITERIA:** Check **ALL** applicable boxes below. Boxes **must** be checked to qualify or authorization process will be delayed.

- Prescriber is a rheumatologist or nephrologist
- Patient is hyperuricemic (serum urate  $\geq 6$ mg/dl at screening)
- Patient has symptomatic hyperuricemia with the presence of at least one of the following:
  - $\geq 1$  tophus
  - 3 or more gout flares within the previous 18 months
  - chronic gouty arthropathy
- Patient has tried and failed a medically appropriate maximum dose of allopurinol or febuxostat or has a contraindication to allopurinol (allergy or GI intolerance) or febuxostat (allergy or Cr Cl  $< 30$ ml/min).
- Failure of allopurinol or febuxostat will be defined as serum urate not being reduced to  $< 6$ mg/dl despite at least three months of appropriate therapy.
- Antihistamines and corticosteroids are to be administered prior to infusion of **Krystexxa™**.
- Dosage regimen prescribed: \_\_\_\_\_

**Medication being provided by** (check applicable box below):

- Location/site of drug administration:** \_\_\_\_\_  
**NPI or DEA # of administering location:** \_\_\_\_\_
- OR**
- Specialty Pharmacy - PropriumRx**

(Continued on next page; Signature page **MUST** be included with request.)

(Signature **MUST** be attached to this request.)

***\*\*Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.\*\****

***\*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.\****

Patient Name: \_\_\_\_\_  
Member Optima #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Prescriber Name: \_\_\_\_\_  
Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Office Contact Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
**DEA OR NPI #:** \_\_\_\_\_

**REVISED/UPDATED:** 8/1/2017; 5/25/2018; 8/23/2018; 10/8/2018; (Reformatted) 2/5/2019