OPTIMA HEALTH COMMUNITY 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 1-844-348-3720.** 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 ≥6mg/dl at screening)
- ❑ Patient has symptomatic hyperuricemia with the presence of at least one of the following:
  - ❑ ≥ 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 < 30ml/min).
- ❑ Failure of allopurinol or febuxostat will be defined as serum urate not being reduced to < 6mg/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**