

OPTIMA HEALTH COMMUNITY CARE

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 below. Incomplete information will delay authorization process.

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 ≥ 6 mg/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 < 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):

Physician's office

OR

Specialty Pharmacy:

PropriumRx

****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 #: _____