

OPTIMA HEALTH PLAN

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 1-844-202-5034. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct.*

Drug Requested: **Krystexxa™** (pegloticase) **(J2507) (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:

Briova SpecialtyRx

****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: _____

Contact Office Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

*Approved by Pharmacy and Therapeutics Committee: 3/17/2011

REVISED/UPDATED: 9/19/2011; 10/4/2011; 3/1/2012; 4/19/2012; 10/9/2012; 4/9/2014; 8/20/2014; 10/31/2014; 4/3/2015; 5/23/2015; 12/30/2015; 1/29/2016; 8/18/2016; 9/22/2016; 11/29/2016; 12/13/2016; 9/15/2017; 10/4/2017.