

# 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 1-844-723-2094. 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 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  $\geq 6$ 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):**

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: \_\_\_\_\_

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; 12/11/2016; 7/24/2017.