# 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 ≥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**

*****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~~; **5/24/2018**