Crysvita

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

*Directions(sig)*_____ *Route of administration*_____

*Dosing frequency*_____

What is the ICD-10 code? _____

Site of Service Questions:

A. Indicate the site of service requested:
- ❑ *Ambulatory Surgical (POS Code 24)*
- ❑ *Off Campus Outpatient Hospital (POS Code 19)*
- ❑ *Office (POS Code 11)*
- ❑ *Home (POS Code 12)*
- ❑ *On Campus Outpatient Hospital (POS Code 22)*

B. Is the patient less than 18 years of age?
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

Send completed form to: Priority Partners Fax: 1-866-212-4756

 JHHC SOC Crysvita SGM 2562-A – 02/2024.

D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation. ❑ Yes ❑ No

Criteria Questions:

1. What is the diagnosis?

❒ X-linked hypophosphatemia (XLH), *Continue to 2*

❒ FGF23-related hypophosphatemia in tumor induced osteomalacia (TIO), *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Is the request for continuation of therapy with the requested medication?
❒ Yes, *Continue to 3*
❒ No, *Continue to 6*

3. Is the patient currently receiving the requested medication through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 6*

❒ No, *Continue to 4*

❒ Unknown, *Continue to 6*

4. Is the patient experiencing benefit from therapy with the requested medication as evidenced by disease stability or disease improvement (e.g., increase or normalization in serum phosphate, improvement in bone and joint pain, reduction in fractures, improvement in skeletal deformities)? ***ACTION REQUIRED***: If Yes, please submit documentation (e.g., chart notes, lab test results). ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Was the supporting documentation included with this request?

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

6. What is the diagnosis?

❒ X-linked hypophosphatemia (XLH), *Continue to 7*

❒ FGF23-related hypophosphatemia in tumor induced osteomalacia (TIO), *Continue to 12*

7. Does the patient have a known PHEX (phosphate regulating gene with homology to endopeptidases located on the X chromosome) mutation confirmed by genetic testing? ***ACTION REQUIRED***: If Yes, please submit genetic test results. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 10*
❒ No, *Continue to 8*

8. Was a known PHEX (phosphate regulating gene with homology to endopeptidases located on the X chromosome) mutation confirmed by genetic testing in a directly related family member with appropriate X-linked inheritance? ***ACTION REQUIRED***: If Yes, please submit genetic test results. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 10*
❒ No, *Continue to 9*

9. Is the patient's serum fibroblast growth factor 23 (FGF23) level above the upper limit of normal or abnormal for the assay? ***ACTION REQUIRED***: If Yes, please submit laboratory test results.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 10*

❒ No, *Continue to 10*

❒ Unknown, *Continue to 10*

10. Does the patient have radiographic evidence of rickets or other bone disease attributed to XLH? ***ACTION REQUIRED***: If Yes, please submit radiographic evidence. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Was the supporting documentation included with this request?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

12. Is the patient's disease associated with phosphaturic mesenchymal tumors that cannot be curatively resected or localized?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Is the patient's diagnosis confirmed by ALL of the following: 1) FGF23 level is above the upper limit of normal or abnormal for the assay; 2) Fasting serum phosphorus levels are less than 2.5 mg/dL; and 3) Ratio of renal tubular maximum reabsorption rate of phosphate to glomerular filtration rate (TmP/GFR) is less than 2.5 mg/dL? ***ACTION REQUIRED***: If Yes, please submit corresponding laboratory documentation. ***ACTION REQUIRED***: Submit supporting documentation

❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Was the supporting documentation included with this request?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Priority Partners Fax: 1-866-212-4756

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.hopkinshealthplans.org