JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Krystexxa

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*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:

Strength/Measure _____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
Directions(sig) _____ *Route of administration* _____
Dosing frequency _____

Criteria Questions:

1. What is the patient's diagnosis?
   ❑ Chronic gout
   ❑ Other, please specify _____
2. What is the ICD-10 code? _____
3. Will the requested drug be used concomitantly with oral urate-lowering therapies (e.g., allopurinol, Uloric [febuxostat])? ❑ Yes ❑ No

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.jhhc.com

4. Will the requested drug be co-administered with weekly oral methotrexate and folic acid or folinic acid supplementation? *If Yes, skip to #6* ❑ Yes ❑ No

5. Does the patient have a contraindication to or clinical reason to avoid oral methotrexate therapy (e.g., alcohol use disorder, alcoholic liver disease, chronic liver disease, breastfeeding, blood dyscrasias, elevated liver transaminases, intolerance or adverse event, hypersensitivity, interstitial pneumonitis, significant pulmonary fibrosis, myelodysplasia, pregnancy, renal impairment, significant drug interaction)? ❑ Yes ❑ No

6. Is this a request for continuation of therapy with the requested drug? *If Yes, skip to #15* ❑ Yes ❑ No

7. Has the patient had at least 2 gout flares per year that were inadequately controlled by colchicine or NSAIDs at the time of initiation of treatment with the requested drug? *If Yes, skip to #9* ❑ Yes ❑ No

8. Has the patient had at least 1 gout tophus or gouty arthritis at the time of initiation of treatment with the requested drug? ❑ Yes ❑ No

9. Has the patient had an inadequate response to at least a 3 month trial of allopurinol at the medically appropriate maximum dose? *If Yes, skip to #13* ❑ Yes ❑ No

10. Does the patient have a clinical reason for not completing at least a 3 month trial of allopurinol at the medically appropriate maximum dose (e.g., severe allergic reaction, intolerance, toxicity, significant drug interaction, severe renal dysfunction)? *If Yes, skip to #13* ❑ Yes ❑ No

11. Has patient had an inadequate response to at least a 3 month trial of Uloric (febuxostat) at the medically appropriate maximum dose? *If Yes, skip to #13* ❑ Yes ❑ No

12. Does the patient have a clinical reason for not completing at least a 3 month trial of Uloric (febuxostat) at the medically appropriate maximum dose (e.g., severe allergic reaction, intolerance, toxicity, significant drug interaction, end stage renal impairment, history of CVD, new CV event)? ❑ Yes ❑ No

13. Has patient had an inadequate response to at least a 3 month trial of probenecid [alone or in combination with allopurinol or Uloric (febuxostat)] at the medically appropriate maximum dose?
If Yes, no further questions ❑ Yes ❑ No

14. Does the patient have a clinical reason for not completing at least a 3 month trial of probenecid at the medically appropriate maximum dose (e.g., severe allergic reaction, intolerance, toxicity, significant drug interaction, known blood dyscrasias, uric acid kidney stones, renal insufficiency)? ❑ Yes ❑ No *If Yes or No, no further questions*

15. Has the patient had two consecutive uric acid levels above 6 mg/dL since starting the requested drug?
❑ Yes ❑ No

16. Is the patient experiencing benefit from therapy (e.g., serum uric acid levels < 6 mg/dl, reduction of tophi, reduction of symptoms and/or flares)? ***ACTION REQUIRED: If 'Yes', please attach chart notes, lab test results or medical records documenting a benefit from therapy (e.g., serum uric acid levels < 6 mg/dl, reduction of tophi, reduction of symptoms and/or flares).*** ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

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

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