

KRYSTEXXA (pegloticase) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Antihyperuricemics** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		total # of pgs: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:		NPI:	State license #:	
LTC facility contact/phone:		Street address:		
Beneficiary name:		Suite #:	City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Medication requested: <input type="checkbox"/> Krystexxa 8 mg/ml vial <input type="checkbox"/> Krystexxa _____			
Strength:	Directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):		DX code (required):	
ALL requests			
Does the beneficiary have glucose-6-phosphate dehydrogenase (G6PD) deficiency?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation of G6PD screening for at-risk beneficiaries.</i>
Will the beneficiary be using Krystexxa concomitantly with any oral urate-lowering medications?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit beneficiary's current complete medication list.</i>
INITIAL requests			
Does the beneficiary have a history of trial and failure of or contraindication or intolerance to maximally tolerated doses of xanthine oxidase inhibitors (e.g., allopurinol, febuxostat)?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation.</i>
Does the beneficiary have a recent uric acid level above goal based on American College of Rheumatology guidelines?		<input type="checkbox"/> Yes – <i>Submit recent lab results.</i> <input type="checkbox"/> No	
Was the beneficiary counseled regarding the following? <i>Check all that apply.</i> <input type="checkbox"/> Appropriate dietary and lifestyle modifications <input type="checkbox"/> Discontinuation of other medications known to precipitate gout attacks		<input type="checkbox"/> Yes – <i>Submit documentation.</i> <input type="checkbox"/> No	
RENEWAL requests			
Did the beneficiary experience improvement in disease severity since initiating treatment with Krystexxa?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation of clinical response.</i>

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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