# Krystexxa

## Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. 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 to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at **1-844-387-1435.**

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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

**Rendering Provider Info:** ❑ **Same as Requesting Provider** **HPHC Provider ID:**_____
**Name:** _____ **NPI#:** _____
**Fax:** _____ **Phone:** _____ **Provider Tax ID:** _____

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

**Additional Demographic Information:**

*Please indicate the place of service for the requested drug:*
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

**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 _____
2. What is the ICD-10 code? _____
3. Will Krystexxa be used concomitantly with oral urate-lowering therapies (e.g., allopurinol, Uloric [febuxostat])?
   ❑ Yes ❑ No
4. Is this a request for continuation of therapy with Krystexxa after at least 3 months of therapy (i.e., six doses)?
   ❑ Yes ❑ No *If No, skip to #7*
5. Is the patient currently receiving Krystexxa through samples or a manufacturer's patient assistance program?
   *If Yes or Unknown, skip to #7* ❑ Yes ❑ No ❑ Unknown
6. Has the patient had 2 consecutive uric acid levels above 6 mg/dL? ❑ Yes ❑ No *No further questions*
7. Has the patient had an inadequate response to at least a 3 month trial of ANY of the following medications at the medically appropriate maximum dose? ***Indicate ALL that apply.***
   ❑ Yes - allopurinol ❑ Yes - Uloric (febuxostat)

**Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-844-851-0882**

❑ Yes - Probenecid (alone or in combination with allopurinol or febuxostat)
❑ None of the above

8. Does the patient have a clinical reason for not completing at least a 3 month trial of ANY of the following medications at the medically appropriate maximum dose (e.g., severe allergic reaction, intolerance, toxicity, significant drug interaction, end stage renal impairment, severe renal dysfunction, known blood dyscrasias, uric acid kidney stones, or renal insufficiency)? ***Indicate ALL that apply.***
❑ Yes - allopurinol ❑ Yes - Uloric (febuxostat)
❑ Yes - Probenecid (alone or in combination with allopurinol or febuxostat)
❑ No
***If Yes, please specify reason(s):***_____

***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)**

**Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-844-851-0882**



**CVS Caremark Prior Authorization ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062**
**Phone: 1-844-387-1435 ● Fax: 1-844-851-0882 ● www.caremark.com**