Krystexxa

HMSACOM - Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

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

Additional Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

Indicate where the drug is being dispensed:

❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
❑ Psychiatric Facility ❑ Pharmacy ❑ Other

Indicate where the drug is being administered:

❑ Ambulatory surgical ❑ Home ❑ Inpatient Hospital
❑ Office ❑ Outpatient Hospital ❑ Pharmacy

What is the ICD-10 code? _____

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

Criteria Questions:

1. What is the patient's diagnosis?

❒ Chronic gout, *Continue to #2*

❒ Other, *Continue to #2*

2. Is the patient an adult (18 years of age or older)?

❒ Yes, *Continue to #3*

❒ No, *Continue to #3*

3. Will the requested drug be co-administered with weekly oral methotrexate and folic acid or folinic acid supplementation?

❒ Yes, *Continue to #5*

❒ No, *Continue to #4*

4. 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, *Continue to #5*

❒ No, *Continue to #5*

5. Is this a request for continuation of therapy with Krystexxa?

❒ Yes, *Continue to #6*

❒ No, *Continue to #10*

6. Was Krystexxa therapy previously authorized by HMSA/CVS for this member?

❒ Yes, *Continue to #7*

❒ No, *Continue to #10*

❒ Unknown, *Continue to #10*

CONTINUATION

7. Is the patient benefiting from therapy with Krystexxa (e.g., serum uric acid levels less than 6 mg/dL, reduction of tophi, reduction of symptoms and/or flares)? ***ACTION REQUIRED****: Attach documentation of clinical benefit*

❒ Yes, *Continue to #8*

❒ No, *Continue to #8*

8. Has the patient had 2 consecutive uric acid levels above 6 mg/dL? ***ACTION REQUIRED****: Attach documentation of current uric acid levels*

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

NEW STARTS

10. Will Krystexxa be used concomitantly with oral urate-lowering therapies (e.g., allopurinol, Uloric [febuxostat])?

❒ Yes, *Continue to #11*

❒ No, *Continue to #11*

11. 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?

❒ Yes, *Continue to #13*

❒ No, *Continue to #12*

12. Has the patient had at least 1 gout tophus or gouty arthritis at the time of initiation of treatment with the requested drug?

❒ Yes, *Continue to #13*

❒ No, *Continue to #13*

Step Therapy with allopurinol and Uloric (febuxostat)

13. Has the patient had an inadequate response to at least a 3-month trial of allopurinol at the medically appropriate maximum dose? ***ACTION REQUIRED****: Attach documentation that describes the trial of allopurinol, including dose and length of therapy*

❒ Yes, *Continue to #15*

❒ No, *Continue to #14*

14. 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, or severe renal dysfunction)? ***ACTION REQUIRED****: Attach documentation that describes the clinical reason*

❒ Yes, *Continue to #15*

❒ No, *Continue to #15*

15. Has the patient had an inadequate response to at least a 3-month trial of Uloric (febuxostat) at the medically appropriate maximum dose? ***ACTION REQUIRED****: Attach documentation that describes the trial of febuxostat, including dose and length of therapy*

❒ Yes, *Continue to #17*

❒ No, *Continue to #16*

16. 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, or established cardiovascular disease)? ***ACTION REQUIRED****: Attach documentation that describes the clinical reason*

❒ Yes, *Continue to #17*

❒ No, *Continue to #17*

Step Therapy with probenecid

17. Has patient had an inadequate response to at least a 3-month trial of probenecid (alone or in combination with allopurinol or febuxostat) at the medically appropriate maximum dose? ***ACTION REQUIRED****: Attach documentation that describes the trial of probenecid, including dose and length of therapy*

❒ Yes, *No Further Questions*

❒ No, *Continue to #18*

18. 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, or renal insufficiency)? ***ACTION REQUIRED****: Attach documentation that describes the clinical reason*

❒ 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 CVS Caremark or the benefit plan sponsor.

X_____

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

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512