Krystexxa

HMSA Medicare Advantage - 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

 Krystexxa HMSAMED C26643-A – 1/2024.

Criteria Questions:

1. What is the diagnosis?

❒ Chronic gout, *Continue to #2*

❒ Other, *No Further Questions*

2. Is this a request for initial therapy or for continuation of therapy?

❒ Initial therapy, *Continue to #5*

❒ Continuation therapy, *Continue to #3*

Continuation

3. Is the member receiving benefit from the requested drug therapy (e.g., serum uric acid levels < 6 mg/dL, reduction of tophi, reduction of symptoms and/or flares)? If 'Yes", medical records (e.g., chart notes, lab test results) documenting response to therapy must be available upon request

❒ Yes, *Continue to #4*

❒ No, *Continue to #4*

4. Has the member had two consecutive serum uric acid levels above 6 mg/dL since starting treatment with the requested drug?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Initial

5. Will the requested drug be used concomitantly with oral urate-lowering therapies?

❒ Yes, *Continue to #6*

❒ No, *Continue to #6*

6. Is the member refractory to conventional therapy (e.g., allopurinol, febuxostat) at the maximum medically appropriate dose?

❒ Yes, *Continue to #8*

❒ No, *Continue to #7*

7. Does the member have a clinical reason to avoid therapy with all conventional therapies? (Please provide the clinical reason in the space provided.)

_____

_____

❒ Yes, *Continue to #8*

❒ No, *Continue to #8*

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

❒ Yes, *No Further Questions*

❒ No, *Continue to #9*

9. Does the patient have a contraindication to or clinical reason to avoid oral methotrexate therapy (e.g., liver disease, breastfeeding, blood dyscrasias, intolerance, hypersensitivity, renal impairment)? (Please provide the clinical reason in the space provided.)

_____
_____

❒ 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)**

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