pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

CRYSVITA (burosumab) PRIOR AUTHORIZATION FORM *(form effective 01/05/2021)*

Prior authorization guidelines for **Crysvita** 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.

☐New request ☐Renewal request	# of pages: _____	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

Drug requested – LOADING dose:	Drug requested – MAINTENANCE dose:
☐Crysvita 10 mg/mL vial # of vials per dose: _____ # of doses requested: _____ ☐Crysvita 20 mg/mL vial # of vials per dose: _____ # of doses requested: _____ ☐Crysvita 30 mg/mL vial # of vials per dose: _____ # of doses requested: _____	☐Crysvita 10 mg/mL vial # of vials per dose: _____ # of doses requested: _____ ☐Crysvita 20 mg/mL vial # of vials per dose: _____ # of doses requested: _____ ☐Crysvita 30 mg/mL vial # of vials per dose: _____ # of doses requested: _____
LOADING dose/directions:	MAINTENANCE dose/directions:

Diagnosis *(submit documentation)*:	Dx code (*required*):	Beneficiary's weight (kg):

Is Crysvita being prescribed by or in consultation with a specialist (e.g., endocrinologist, geneticist, nephrologist, oncologist, rheumatologist, other specialist experienced in the treatment of patients with metabolic bone disease, etc.)?	☐Yes ☐No *Submit documentation of consultation, if applicable.*
Does the beneficiary have severe renal impairment or end stage renal disease?	☐Yes ☐No *Submit documentation.*
Will the beneficiary be taking oral phosphate and/or an active vitamin D analog while taking Crysvita?	☐Yes ☐No *Submit beneficiary's complete current medication list.*

INITIAL requests

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐Has a baseline (before treatment) fasting serum phosphate level that is below the reference range for age
☐Has laboratory evidence of renal phosphate wasting (i.e., low %TRP and/or low TmP/GFR
☐Has a baseline FGF23 level that is normal or above the assay-specific reference range for age
☐Is being treated for X-linked hypophosphatemia (XLH) and:
- ☐Has a diagnosis of XLH confirmed by at least one of the following:
  - ☐Confirmed *PHEX* gene mutation
  - ☐Positive family history of XLH

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- ☐ Presence of typical clinical features of XLH (e.g., in children: abnormal gait, lower limb deformity, decreased growth velocity, etc.; in adults: short stature, osteomalacia, bone pain, osteoarthritis, pseudofractures, stiffness, enthesopathies, poor dental condition, etc.)
- ☐ At least one of the following:
  - ☐ Has open epiphyses
  - ☐ Is experiencing clinical signs and/or symptoms of XLH (e.g., limited mobility, musculoskeletal pain and/or stiffness, bone fractures or pseudofractures, decreased physical function, renal calculi, etc.)

☐ Is being treated for **tumor-induced osteomalacia** (TIO) and:

- ☐ Has a diagnosis of active TIO confirmed by at least one of the following:
  - ☐ Identification and localization of the underlying tumor that is unresectable or pending resection
  - ☐ Other causes of genetic and acquired renal phosphate wasting disorders have been reasonably ruled out

RENEWAL requests

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐ Experienced an increase in fasting serum phosphate level from baseline

☐ Has a fasting serum phosphate level that is below or within the reference range for age

☐ For a beneficiary with **open epiphyses**, is experiencing clinical benefit from Crysvita based on the prescriber's assessment

☐ For all other beneficiaries, experienced improvement of the signs and/or symptoms of the condition (e.g., decreased number of fractures, improved fracture healing, improved bone mineralization, decreased fatigue, pain, and/or stiffness, improved functional capacity, etc.)

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

Prescriber Signature:	Date: