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

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.

☐New request ☐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

Drug requested: ☐Krystexxa 8 mg/ml vial ☐Krystexxa _____		
Directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (required):	

ALL requests	
Is Krystexxa being prescribed by or in consultation with a specialist?	☐Yes ☐No *Submit documentation of consultation if applicable.*
Does the beneficiary have glucose-6-phosphate dehydrogenase (G6PD) deficiency?	☐Yes ☐No *Submit documentation of G6PD screening for at-risk beneficiaries.*
Will the beneficiary be using Krystexxa concomitantly with any oral urate-lowering medications?	☐Yes ☐No *Submit beneficiary's current complete medication list.*
INITIAL requests	
Does the beneficiary have a history of trial and failure of maximally tolerated doses of xanthine oxidase inhibitors (e.g., allopurinol, febuxostat) as indicated by any of the following? *Check all that apply.* ☐Continues to have frequent gout flares (≥2 flares per year) ☐Has non-resolving subcutaneous tophi	☐Yes ☐No *Submit documentation.*
Does the beneficiary have a recent uric acid level that is above goal (based on ACR guidelines) despite maximally tolerated doses of xanthine oxidase inhibitors (e.g., allopurinol, febuxostat)?	☐Yes ☐No *Submit lab results.*
Does the beneficiary have a contraindication or an intolerance to maximally tolerated doses of xanthine oxidase inhibitors (e.g., allopurinol, febuxostat)?	☐Yes ☐No *Submit documentation.*
Was the beneficiary counseled regarding the following? *Check all that apply.* ☐Appropriate dietary and lifestyle modifications ☐Discontinuation of other medications known to precipitate gout attacks	☐Yes – *Submit documentation.* ☐No
RENEWAL requests	
Did the beneficiary experience improvement in disease severity since initiating treatment with Krystexxa?	☐Yes ☐No *Submit documentation of clinical response.*

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

Prescriber Signature:	Date: