Updated: 11/2018
PARP Approved: 11/2018

Prior Authorization Criteria

**Krystexxa (pegloticase)**

All requests for Krystexxa (pegloticase)require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Coverage may be provided with a diagnosis of chronic gout in adult patients refractory to conventional therapy and the following criteria is met:

- The member must be 18 years of age or older
- Documentation the member was screened and does not have Glucose-6-phosphate dehydrogenase (G6PD) Deficiency
- The medication must be prescribed by or in consultation with a rheumatologist
- The member must have a diagnosis of gout
- There must be documentation of a recent (within 1 month) serum uric acid level ≥ 6 mg/dL
- The member must have tried and failed or had an intolerance or contraindication to 3 months of therapy with allopurinol at 300mg per day
    - Failure is considered the inability to normalize uric acid to less than 6mg/dL
- The member must have tried and failed allopurinol in combination with another agent indicated in the treatment of gout for at least 3 months (i.e. lesinurad, probenecid, etc.). (Unless member has an intolerance or contraindication to any of the individual therapies)
    - Failure is considered the inability to normalize uric acid to less than 6mg/dl
- If the member has an intolerance or contraindication to allopurinol the member must try at least one other agent indicated in the treatment of gout for at least 3 months (i.e. lesinurad, probenecid, etc.). (Unless member has an intolerance or contraindication to all other available gout therapies)
- The member must not have any contraindications to the use of Krystexxa
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria:**
    - The member must have documentation from the prescriber indicating improvement or stabilization in condition
    - Documentation of two recent consecutive (within the last 2 months) serum uric acid levels.
        - Rationale from the prescriber for why treatment must be continued if serum uric acid levels increase to above 6 mg/dL, particularly when 2 consecutive levels above 6 mg/dL are observed.
- **Reauthorization Duration of Approval:** 6 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Gateway Health

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# KRYSTEXXA (PEGLOTICASE) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health[SM] Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
**PHONE**: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

## PROVIDER INFORMATION

| | |
|---|---|
| Requesting Provider: | NPI: |
| Provider Specialty: | Office Contact: |
| Office Address: | Office Phone: |
| | Office Fax: |

## MEMBER INFORMATION

| | |
|---|---|
| Member Name: | DOB: |
| Gateway ID: | Member weight: _____pounds or _____kg |

## REQUESTED DRUG INFORMATION

| | |
|---|---|
| Medication: | Strength: |
| Frequency: | Duration: |
| Is the member currently receiving requested medication? ☐ Yes ☐ No | Date Medication Initiated: |

## Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

## Place of Service Information

| | |
|---|---|
| Name: | NPI: |
| Address: | Phone: |

## MEDICAL HISTORY (Complete for ALL requests)

☐ **Member's Diagnosis:** ☐ Chronic Gout ☐ Other _____

Does the member have Glucose-6 phosphate dehydrogenase (G6PD) deficiency? ☐ Yes ☐ No

Serum uric acid level: _____ Date taken: _____

| Medication Name | Strength/ Frequency | Dates of Therapy | Status (Discontinued & Why/Current) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## REAUTHORIZATION

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No
Please describe:

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| | |
|---|---|
| Member Name: DOB:<br>Gateway Health ID | |
| 2 Consecutive serum uric acid levels: _____ Date taken: _____<br>_____ Date taken _____ | |
| **SUPPORTING INFORMATION or CLINICAL RATIONALE** | |
| | |
| | |
| | |
| **Prescribing Provider Signature** | Date |
| | |