Updated: 9/2025
DMMA Approved: 9/2025

Request for Prior Authorization for Krystexxa (pegloticase)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

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

Krystexxa (pegloticase) Prior Authorization Criteria:

- The member must be 18 years of age or older
- The medication must be prescribed by or in consultation with a rheumatologist
- Documentation the member will be using the medication in combination with methotrexate unless methotrexate is contraindicated or not clinically appropriate
- An attestation from the prescriber that the member has discontinued all oral urate-lowering medications prior to starting Krystexxa and will not restart therapy with an oral urate-lowering agent while on Krystexxa
- 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
    - Failure is considered both of the following:
        - the inability to normalize uric acid to less than 6mg/dL
        - frequent gout flares (≥2 flares/year) and/or nonresolving subcutaneous tophi
- The member must have tried and failed or had an intolerance or contraindication to 3 months of therapy with at least one of the following:
    - allopurinol in combination with an uricosuric agent (i.e. probenecid.)
    - another xanthine oxidase inhibitor (XOI) (i.e. febuxostat (non-preferred XOIs require prior authorization))
    - Failure is considered both of the following:
        - the inability to normalize uric acid to less than 6mg/dL
        - frequent gout flares (≥2 flares/year) and/or nonresolving subcutaneous tophi
- 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 12 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:** 12 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.

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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 Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:00am to 7:00pm

PROVIDER INFORMATION

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

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight: _____	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

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)

Diagnosis: ☐ Chronic Gout ☐ Other _____

Serum uric acid level: _____ Date taken: _____

Has the member discontinued all oral urate lowering medications prior to starting therapy and will the member stay off all urate lowering medications while on therapy with Krystexxa? ☐ Yes ☐ No

Will the member be using Krystexxa in combination with methotrexate? ☐ Yes ☐ No
If no please explain why: _____

REAUTHORIZATION

Has the member shown improvement or stabilization? ☐ Yes ☐ No
2 Consecutive serum uric acid levels: _____ Date taken: _____
_____ Date taken _____

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Member Name:	DOB:
Member ID:	

CURRENT or PREVIOUS THERAPY

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

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date

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