



Updated: 07/2024
DMMA Approved: 07/2024

Request for Prior Authorization for Crysvida (burosumab-twza)

Website Form – www.highmarkhealthoptions.com

Submit request via: Fax - 1-855-476-4158

All requests for Crysvida (burosumab-twza) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Crysvida (burosumab-twza) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of X-linked hypophosphatemia (XLH) and the following criteria is met:

- Confirmation of the diagnosis by at least one of the following:
 - Genetic test showing a PHEX gene mutation (phosphate regulating gene with homology to endopeptidase on the X chromosome)
 - Serum fibroblast growth factor 23 (FGF23) level > 30 pg/mL
- Member must be 6 months or older
- Must be prescribed by or in consultation with a physician who is experienced in the management of patients with metabolic bone disease.
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines.
- An attestation from the provider the Crysvida will not be used together with oral phosphate and active vitamin D analogs
- Baseline fasting serum phosphorus concentration that is below the reference range for the member's age (reference range must be provided)
- For members under 18 years of age documentation of one of the following:
 - Baseline recumbent length/standing height z score
 - Baseline serum alkaline phosphatase activity
 - Baseline Thacher Rickets Severity Score (RSS)
- For members 18 years and older documentation of one of the following:
 - An attestation from the provider that the member is experiencing skeletal pain
 - Total healing fracture amount
 - Baseline osteoid volume/bone volume
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
 - For members under 18 years of age
 - An increase in fasting serum phosphorus from baseline taken within last 12 months but not greater than 5.0mg/dL
 - Documentation the member has a positive clinical response or stabilization in their disease demonstrated by one of the following:
 - An increase in height z score from baseline
 - A decrease in serum alkaline phosphatase activity from baseline

- A decrease in the RSS score from baseline or a positive Radiographic Global Impression of Change (RGI-C) score.
- For members 18 years and older
 - An increase in fasting serum phosphorus from baseline taken within last 12 months (the level must also be below the normal range lab; reference range must be provided)
 - Documentation the member has a positive clinical response or stabilization in their disease demonstrated by one of the following:
 - An attestation there has been improvement in the member's pain
 - Total fractures healing after starting therapy
 - A decrease in osteoid volume/bone volume from baseline
- **Reauthorization Duration of Approval: 12 months**

Coverage may be provided with a diagnosis of FGF23-related hypophosphatemia in Tumor Induced Osteomalacia and the following criteria is met:

- Member must be 2 years of age or older
- Documentation member has a phosphaturic mesenchymal tumor that cannot be resected or localized
- Baseline fasting serum phosphorus concentration that is below the reference range for the member's age (reference range must be provided)
- Must be prescribed by or in consultation with a hematologist or oncologist
- **Initial Duration of Approval: 12 months**
- **Reauthorization criteria**
 - An increase in fasting serum phosphorus from baseline taken within last 12 months (the level must also be below the normal range lab; reference range must be provided)
 - Documentation the member has a positive clinical response or stabilization in their disease demonstrated by one of the following:
 - An attestation there has been improvement in the member's pain
 - Total fractures healing after starting therapy
 - A decrease in osteoid volume/bone volume from baseline
- **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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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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**CRYSVITA (BUROSUMAB-TWZA)
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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)

Member's Diagnosis: X-Linked Hypophosphatemia Tumor- Induced Osteomalacia Other _____

For X-Linked Hypophosphatemia:
How was the member's diagnosis confirmed? (please submit documentation)
 genetic test serum fibroblast growth factor 23 level > 30 pg/ml
Will Crysvita be used in combination with oral phosphate or vitamin D analogs? Yes No
Baseline fasting serum phosphorus concentration: _____ reference range _____

For members <18 years of age please provide at least one of the following:
Baseline recumbent length/standing height z score: _____
Baseline serum alkaline phosphatase activity: _____
Baseline Thacher Rickets Severity Score (RSS) _____

For members ≥ 18 years of age please provide at least one of the following:
Is the member experiencing skeletal pain? Yes No Total healing fracture amount: _____
Baseline osteoid volume/bone volume: _____

Member Name:	DOB:
Member ID	

For Tumor-Induced Osteomalacia

Does the member have a phosphaturic mesenchymal tumor that cannot be resected or localized? Yes No
 Baseline fasting serum phosphorus concentration: _____ reference range _____

REAUTHORIZATION

Baseline fasting serum phosphorus concentration _____ reference range _____ date taken _____
 Current fasting serum phosphorus concentration: _____ reference range _____ date taken _____

For members <18 years of age please provide at least one of the following:

Baseline recumbent length/standing height z score _____ date taken _____
 Current recumbent length/standing height z score _____ date taken _____
 Baseline serum alkaline phosphatase activity _____ date taken _____
 Current serum alkaline phosphatase activity _____ date taken _____

Baseline Thacher Rickets Severity Score (RSS) _____ date taken _____
 Current Thacher Rickets Severity Score (RSS) or Radiographic Global Impression of Change Score _____ date taken _____

For members ≥ 18 years of age with X-linked Hypophosphatemia or all members with Tumor-induced Osteomalacia please provide at least one of the following:

Total healing fracture amount before starting therapy: _____ date taken _____
 Current healing fracture amount after starting therapy: _____ date taken _____
 Has the member had an improvement in skeletal pain from baseline? Yes No
 Baseline osteoid volume/bone volume _____ date taken _____
 Current osteoid volume/bone volume _____ date taken _____

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

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date