

**Request for Prior Authorization for Crysvida (burosumab-twza)**  
**Website Form – [www.highmarkhealthoptions.com](http://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 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.

**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) 325-6253 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:
Health Options ID:	Member weight: _____ pounds or _____ kg

**REQUESTED DRUG INFORMATION**

Medication:	Strength:
Frequency:	Duration:
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  Other \_\_\_\_\_

How was the member's diagnosis confirmed? (please submit documentation)  
 genetic test  serum fibroblast growth factor 23 level > 30 pg/ml

Will Crysvida 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:
Health Options ID	

**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 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