Prior Authorization Request Form for Krystexxa

envolve Pharmacy Solutions

pa health & wellness

FAX this completed form to (877) 386-4695

OR Mail requests to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
Office Contact Name:	Group #:
Group Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)		
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Does the member have glucose-6-phosphate dehydrogenase (G6PD) deficiency?	☐ Yes ☐ No	*Submit documentation of G6PD screening for at risk members*
Krystexxa will not be used concomitantly with oral urate-lowering agents?	☐ Yes ☐ No	
Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Antihyperuricemics? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No	*Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.*

☐ If not prescribed by one of the following specialist rheumatologist or endocrinologist, please indicate a specialist consulted:_____

☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

TREATMENT OF CHRONIC GOUT:

- ☐ Member does not have a history of a contradiction to Krystexxa
- ☐ Recent uric acid level above goal based on American College of Rheumatology guidelines:_____(submit labs)
- ☐ Member was counseled regarding the following:
  - ☐ Appropriate dietary and lifestyle modifications
  - ☐ Discontinuation of other medications know to precipitate gout attacks

FOR USE OF A URIC ACID LOWERING MEDICATION FOR MORE THAN 6 MONTHS:

- ☐ Documentation of improvement in disease severity since initiating Krystexxa, as evidenced by:_____

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date: