Cigna®

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

# Krystexxa
## (pegloticase)

| PHYSICIAN INFORMATION | | | PATIENT INFORMATION | | |
|---|---|---|---|---|---|
| * Physician Name: | | | *Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.* | | |
| Specialty: | * DEA, NPI or TIN: | | | | |
| Office Contact Person: | | | * Patient Name: | | |
| Office Phone: | | | * Cigna ID: | * Date of Birth: | |
| Office Fax: | | | * Patient Street Address: | | |
| Office Street Address: | | | City: | State: | Zip: |
| City: | State: | Zip: | Patient Phone: | | |

**Urgency:**
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

**Medication requested:**
☐ Krystexxa 8 mg/ml vial ICD10:

Dose and Quantity: Duration of therapy: Frequency of therapy:
J-Code:

Is this initial therapy, or is the patient currently receiving Krystexxa?

☐ Initial therapy
☐ Currently receiving

What is the patient's diagnosis or reason for treatment?
☐ Chronic Gout
☐ Known Glucose-6-Phosphate Dehydrogenase (G6PD) Deficiency
☐ Other (please specify):

(if currently receiving) Is the patient continuing therapy with the requested medication to maintain response/remission? ☐ Yes ☐ No

(if currently receiving) Has the patient responded to therapy with evidence of serum uric acid level less than 6 mg/dL with continued Krystexxa treatments? ☐ Yes ☐ No

**Where will this medication be obtained?**
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

**Facility and/or doctor dispensing and administering medication:**
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

**Where will this drug be administered?**
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

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

**Clinical Information:**

****This drug requires supportive documentation (chart notes, lab/test results, etc) be attached with this request****

Does the patient have at least one tophus? ☐ Yes ☐ No

(if no) Does the patient have a history of two previous gout flares in the past year (prior to the current flare)? ☐ Yes ☐ No

Is this medication being prescribed by, or in consultation with, a rheumatologist or a nephrologist? ☐ Yes ☐ No

Has the patient had an inadequate response, defined as a serum uric acid level that remained higher than 6 mg/dL, following a 3-month trial of a xanthine oxidase inhibitor? (Note: Examples of xanthine oxidase inhibitors include allopurinol, febuxostat.) ☐ Yes ☐ No

(if no) Does the patient have a contraindication or has had an intolerance to a trial of allopurinol, according to the prescriber? ☐ Yes ☐ No

Has the patient had an inadequate response, defined as a serum uric acid level that remained higher than 6 mg/dL, following a 3-month trial of a uricosuric agent? (Note: Examples of uricosuric agents include probenecid, fenofibrate, losartan) ☐ Yes ☐ No

(if no) Does the patient have renal insufficiency (for example, decreased glomerular filtration rate), according to the prescriber? ☐ Yes ☐ No

Will the requested medication be used in combination with one of the following: a. Methotrexate, b. Leflunomide, c. Mycophenolate mofetil, or d. Azathioprine? ☐ Yes ☐ No

Will the requested medication be used in combination with an oral urate-lowering drug for the treatment of gout? (Note: Examples of oral urate-lowering drugs include allopurinol, febuxostat, probenecid) ☐ Yes ☐ No

**Additional pertinent information:** ***Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).***

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature:**_____ **Date:**_____

**Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.**

*Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.*

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