UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Crysvita (burosumab-twza)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: *(**ALL** of the following criteria must be met)*

❑ Medication is prescribed by or in consultation with a physician who specializes in the disease treatment

❑ The provider attests that if used concurrent, oral phosphates and/or active vitamin D analogs will be discontinued 1 week prior to treatment initiation.

❑ Patient does not have severe renal impairment or end stage renal disease.

❑ Patient does not have normal/above normal serum phosphate ranges for age.

Select applicable:

❑ Diagnosis of X-linked hypophosphatemia (XLH) (*All* must be met)
- ❑ The patient is at least 6 months of age and older
- ❑ The diagnosis was confirmed by genetic testing for mutations in the *PHEX* gene on the X chromosome.
- ❑ Lab results of low blood levels phosphorus and high levels of the hormone FGF23, demonstrating persistent hypophosphatemia

❑ Diagnosis of tumor-induced osteomalacia (*All* must be met)
- ❑ The patient is at least 2 years of age and older
- ❑ The provider has determined that the tumor cannot be identified or completely resected

Re-authorization Criteria:

Updated letter with medical justification or updated chart notes demonstrating positive clinical response.

Initial Authorization: Up to six (6) months

Re-authorization: Up to one (1) year

Note: Use appropriate HCPCS code for billing

- Coverage and Reimbursement code look up: https://health.utah.gov/stplan/lookup/CoverageLookup.php
- HCPCS NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date