

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

KRYSTEXXA (pegloticase)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES AND THIS COMPLETED
FORM TO 855-828-4992**

CRITERIA FOR GOUT:

- Minimum age requirement: 18 years old.
- Documented failure on, or contraindication to allopurinol
- Documented failure on, or contraindication to probenecid.
- Documented failure on, or contraindication to colchicine.
- Prescribed by a rheumatologist or nephrologist informed about proper procedures.
- Completion of a G6PD screen before treatment initiation (please submit results).
- Dose not to exceed one 8mg infusion every 14 days.
- Description of the anaphylactic measures to be taken prior to infusion.
- Description of proper resussitative procedures in place to treat anaphylaxis

NOTES:

- Krystexxa is NOT indicated to treat asymptomatic gout or prophylaxis of gouty attacks. Requests for such indications will be denied.
- As per indication, treatment to prevent anaphylaxis MUST be given with EACH Krystexxa infusion.
- This medication is only payable through J-code J2507 to a physician's office. Patients with ACO's will have to make arrangements with their ACO for coverage.

AUTHORIZATION:

The initial prior authorization will be approved for 3 months.

RE-AUTHORIZATION:

- Documentation from progress notes describing positive response to treatment, and lack of serious anaphylaxis or side effects.
- Reauthorization will not be given if a patient has more than 2 serum uric acid levels over 6mg/dL *after* treatment initiation
- Reauthorizations will be approved for 6 months

08/07/2012

<https://medicaid.utah.gov/pharmacy/>