

Krystexxa

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-396-4139

FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Incomplete responses may delay this request.

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	Provider NPI #:

Patient Name:		Patient UPMC Health Plan ID Number:		Patient DOB:	Patient Age:
Drug Requested:	Strength:	Frequency:	Qty Dispensed:		

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

<input type="checkbox"/> New medication	If ongoing, provide date started:	If medication is ongoing, Did member Show improvement while on therapy?	<input type="checkbox"/> Yes
<input type="checkbox"/> Ongoing medication			<input type="checkbox"/> No

Diagnosis:

Please indicate place of administration?	<input type="checkbox"/> Physician Office	Please indicate how medication will be billed:
	<input type="checkbox"/> Hospital/Facility	
Please provide facility/provider name and address:		<input type="checkbox"/> Billed directly by the provider via JCODE Provide JCODE: _____
		<input type="checkbox"/> Billed by a pharmacy and delivered to the provider
		<input type="checkbox"/> Billed by a pharmacy and delivered to the patient

MEDICAL HISTORY

Baseline Serum Uric Acid Level _____	Date of last test _____	Number of gout flares ups in the past 18 months _____
--------------------------------------	-------------------------	---

Does the member have a history of at least ONE gout tophus or of gouty arthritis? Yes No

Has member tried and failed Allopurinol 800mg or Uloric 80mg?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Please complete below: List adverse reactions/side effects/reason for discontinuation
Medication	Frequency	Dates of Trial	
		Start Date End Date	

Please include documentation of Uric acid levels during 3 months of treatment with Uloric or Allopurinol (including dates)

Is this request for a reauthorization? Yes No If yes, please include the following documentation:

- Documentation showing members disease has improved
- Documentation showing the members last 2 uric acid levels
- Documentation showing adherence with every 2 week dosing regimen

Please list all other medications the member has previously tried or is currently using.

Medication Name	Strength	Frequency	Dates of Trial		List adverse reactions/side effects/reason for discontinuation
			Start Date	End Date	

Please provide any additional information which should be considered in the space below:
