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.

☐ **New medication** ☐ **Ongoing medication**	**If ongoing, provide date started:**	**If medication is ongoing, Did member Show improvement while on therapy?**	☐**Yes** ☐**No**

Diagnosis:

Please indicate place of administration?	☐**Physician Office** ☐**Hospital/Facility**	**Please indicate how medication will be billed:** ☐ **Billed directly by the provider via JCODE** **Provide JCODE:__________________** ☐ **Billed by a pharmacy and delivered to the provider** ☐ **Billed by a pharmacy and delivered to the patient**
Please provide facility/provider name and address:		

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? ☐ **Yes** ☐ **No** **If Yes, Please complete below:**

Medication	Frequency	Dates of Trial		List adverse reactions/side effects/reason for discontinuation
		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: