P.O. Box 30192
Salt Lake City, UT 84130-0192
801-442-4912 or 800-442-3129
Fax 801-442-3006

selecthealth

PREAUTHORIZATION FORM
Krystexxa™
(pegloticase)

Therapeutic use: treatment of chronic gout in adult patients refractory to conventional therapy
Quantity Limit: 8 mg IV infusion once every two weeks
Authorization Period: initial authorization of 6 months

Patient's name ______________________________

Patient's ID# ☐☐☐ ☐☐ ☐☐☐☐ DOB ☐☐/☐☐/☐☐☐☐

ICD-9 ☐☐☐ ☐☐ ☐☐☐ ☐☐ ______________________________

Physician's name ______________________________

Physician's Ph# (☐☐☐) ☐☐☐-☐☐☐☐ Fax# ☐☐☐-☐☐☐☐

Physician's signature______________________ Date signed ☐☐/☐☐/☐☐☐☐

Supervising Physician's name________________ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Is the prescribing physician a rheumatologist?	❑ Yes	❑ No
2.	a. Has the patient been compliant on high dose allopurinol for at least 6 months? If not, please note any contraindication or reason for early discontinuation ______________________________	❑ Yes	❑ No
	b. Has the patient been compliant on high dose Uloric for at least 6 months? If not, please note any contraindication or reason for early discontinuation: ______________________________	❑ Yes	❑ No
3.	For initial authorization: please provide most recent serum uric acid level prior to Krystexxa therapy: ________________ mg/dL. For reauthorization: please provide a serum uric acid level taken after at least 4 months of therapy with Krystexxa: ________________ mg/dL. (SUA level should be taken immediately prior to the next infusion)		
4.	Is the patient experiencing any of the following? a. ≥ 3 gout flares in the last 18 months b. ≥ 1 tophus at most recent evaluation c. Chronic gouty arthritis	 ❑ Yes ❑ Yes ❑ Yes	 ❑ No ❑ No ❑ No
5.	a. Has the patient been diagnosed with G6PD deficiency? b. If the patient is of African American or Mediterranean ancestry, have they been screened for G6PD deficiency?	❑ Yes ❑ Yes or N/A	❑ No ❑ No

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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