mercy care

Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/completecare-forproviders/pharmacy

Krystexxa
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information			
What medication(s) has member tried and failed for this diagnosis? Please specify:			
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No	Diagnosis:	ICD-10 Code:	
Are there any contraindications to formulary medications? If yes, please specify:		☐ Yes	☐ No
Directions for Use:	Strength:	Dosage Form:	
	Quantity: / Day Supply:	Duration of Therapy/Use:	

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information					
Is the diagnosis CHRONIC GOUT refractory to conventional therapy?	☐ Yes	☐ No			
Has the member experienced any of the following in the past 18 months?	☐ 3 gout flares inadequately controlled by colchicine or NSAIDs	☐ 1 gout tophus or gouty arthritis			
Was member screened and found to NOT have G6PD Deficiency?	☐ Yes	☐ No	Will provider attest to monitoring during and after infusion for possible anaphylaxis, and infusion related reactions?	☐ Yes	☐ No
Documented 3 months trial and failure, or intolerance with the following at maximum medically appropriate doses, or member has contraindication to the agents:	☐ Allopurinol or febuxostat ☐ Probenecid (alone of in combination with allopurinol or febuxostat)				
Will medication be used concomitantly with oral urate-lowering	☐ Yes	☐ No			

therapies?		

☐ **Renewal Requests ONLY**		
Has member had 2 consecutive uric acid levels NOT ABOVE 6mg/dL since starting treatment?	☐ Yes	☐ No

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.