



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/chp-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:		Height:	
		<input type="checkbox"/> Male	<input type="checkbox"/> Female		
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):		Diagnosis:		ICD-10 Code:	
		Yes	No		
Are there any contraindications to formulary medications? If yes, please specify:				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Directions for Use:		Strength:		Dosage Form:	
		Quantity:	Day Supply:	Duration of Therapy/Use:	
Turn-Around Time for Review					
<input type="checkbox"/> Standard – (24 hours)		<input type="checkbox"/> 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?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Has the member experienced any of the following in the past 18 months?		<input type="checkbox"/> 3 gout flares inadequately controlled by colchicine or NSAIDs		<input type="checkbox"/> 1 gout tophus or gouty arthritis	
Was member screened and found to NOT have G6PD Deficiency?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Will provider attest to monitoring during and after infusion for possible anaphylaxis, and infusion related reactions?	
				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Documented 3 months trial and failure, or intolerance with the following at maximum medically appropriate doses, or member has contraindication to the agents:		<input type="checkbox"/> Allopurinol or febuxostat			
		<input type="checkbox"/> Probenecid (alone or in combination with allopurinol or febuxostat)			
Will medication be used concomitantly with oral urate-lowering			<input type="checkbox"/> Yes	<input type="checkbox"/> No	

therapies?		
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Renewal Requests ONLY

Has member had 2 consecutive uric acid levels NOT ABOVE 6mg/dL since starting treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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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 833-711-0776 to check the status of a request.