Pegloticase (Krystexxa®) Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____ Does patient have other coverage? ☐ Yes ☐ No
Group #: _____ If yes, provide ID#: _____ Carrier Name: _____
Insured: _____ Insured: _____

Medicare: ☐ Yes ☐ If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **Orthopedics** ☐ **Rheumatologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Krystexxa: Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____
Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

☐ Yes ☐ No Does the patient have a documented diagnosis of gout?
☐ Yes ☐ No Is the patient symptomatic?
How many gout flares has the patient had in the past 18 months? _____
Please provide the dates of the gout flares: ____/____/____ , ____/____/____ , ____/____/____
☐ Yes ☐ No Was the patient taking colchicine and/ or non-steroidal anti-inflammatory drugs during the flares?
→ ***If yes***, please indicate the medications taken:
☐ Colchicine ☐ Non-steroidal anti-inflammatory medications- please identify: _____
☐ Yes ☐ No Is there clinical evidence of gout tophus?
☐ Yes ☐ No Is there clinical evidence of gouty arthritis?
☐ Yes ☐ No Did the patient fail to normalize serum uric acid after taking a maximum medically appropriate dose of a xanthine oxidase inhibitor?
→ ***If no***, ☐ Yes ☐ No Does the patient have a contraindication to xanthine oxidase inhibitors?
→ ***If yes***, please specify the contraindication:
☐ Pregnancy ☐ Allergic reaction ☐ Myelosuppression ☐ Hepatotoxicity ☐ Renal Impairment
☐ Medication interaction ☐ Other- please explain: _____
→ ***If yes***, please indicate the xanthine oxidase inhibitor:
☐ allopurinol (Zyloprim, Aloprim) ☐ febuxostat (Uloric) ☐ Other: _____
Please indicate how long the patient was taking the xanthine oxidase inhibitor in months: _____ Months

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

What is the patient's serum uric acid level in mg/ dL and date obtained? _____ mg/dL Date obtained: ____/____/____

☐ Yes ☐ No Has the patient undertaken appropriate lifestyle modifications?

→ ***If yes***, please check all that apply:

- ☐ Discontinuing or changing medications that are known to precipitate gout attacks
- ☐ Diet changes (low-purine diet, reducing refined carbohydrates, limit meats, increases vegetables and fruit)
- ☐ Decreasing alcohol consumption
- ☐ Limiting drinks rich in fructose
- ☐ Modifications unknown if selected
- ☐ Other: _____

☐ Yes ☐ No Does the patient have G6PD (Glucose-6-phosphate dehydrogenase deficiency) deficiency?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.