Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Krystexxa
(pegloticase)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Krystexxa 8 mg/ml vial ICD10:

Dose and Quantity: Duration of therapy: J-Code:

Is this a new start or a continuation of therapy? ☐ new start ☐ continued therapy
(if continued therapy) Does your patient have a history of positive response? ☐ Yes ☐ No
If *yes*, what is your patient's serum uric acid level? _____mg/dL
If *yes*, has there been improvement in symptoms? ☐ Yes ☐ No

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Information:

****NEW STARTS/NEW TO CIGNA: This drug requires supportive documentation (chart notes, lab/test results, etc) be attached with this request****

What is the patient's diagnosis?
☐ Asymptomatic Hyperuricemia
☐ chronic gout
☐ Chronic Kidney Disease
☐ Known Glucose-6-Phosphate Dehydrogenase (G6PD) Deficiency
☐ Other (please specify):

Which of the following has your patient had (select all that apply)?
☐ at least 3 gout flares in the previous 18 months
☐ at least 1 gouty tophus
☐ chronic gouty arthritis
☐ none of the above

Is Krystexxa being prescribed by, or in consultation with, a rheumatologist, nephrologist or prescriber who specializes in gout? ☐ Yes ☐ No

Has the patient had inadequate efficacy, defined as a serum uric acid level that remained greater than 6 mg/dL, following a 3-month trial of the maximum medically appropriate dose of ONE xanthine oxidase inhibitor [maximum recommended dosage - allopurinol (Zyloprim) is 800 mg/day / febuxostat (Uloric) is 80 mg/day]? ☐ Yes ☐ No

(if yes) Has the patient had inadequate efficacy, defined as a serum uric acid level that remained greater than 6 mg/dL, following a 3-month trial of the combination of ONE xanthine oxidase inhibitor and ONE uricosuric agent (for example, probenecid)? ☐ Yes ☐ No

(if no to either of the above) Does the patient have either a contraindication per FDA label or an intolerance to one the following:
A. Allopurinol (Zyloprim) (for example, hypersensitivity, concomitant use of azathioprine, mercaptopurine, or theophylline) and/or
B. Uricosuric agents [probenecid (for example, hypersensitivity, renal insufficiency)]? ☐ Yes ☐ No

Additional Information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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