Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
CRYSVITA (burosumad-twza) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **CRYSVITA (burosumad-twza).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: http://www.providers.kaiserpermanente.org/mas/formulary.html

1 – Patient Information

Patient Name: _______________________________ Kaiser Medical ID#: __________________ Date of Birth: ______________

2 – Prescriber Information

Is the prescriber a Specialist in metabolic bone disorders and/or Oncologist* when applicable? □ No □ Yes

If consulted with a specialist, specialist name and specialty: ____

Prescriber Name: _______________________________ Specialty: _____________________________ NPI: __________________

Prescriber Address: ____

Prescriber Phone #: ___________________________Prescriber Fax #: ____________________________

3 – Pharmacy Information

Pharmacy Name: _________________________________ Pharmacy NPI: ____

Pharmacy Phone #________________________________ Pharmacy Fax #: ____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: ____
Sig: ____

Drug 2: Name/Strength/Formulation: ____
Sig: ____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, State date: ________________________
2. Indicate the Member's diagnosis for the requested medication: ____
3. Is member ≥1 year of age? **AND**
   □ No □ Yes
4. Member has a diagnosis of X-linked hypophosphatemia (XLH) supported by at least one of the following: genetic testing (PHEX mutation) OR family member with X-linked inheritance OR serum fibroblast growth factor 23 (FGF23) level >30 pg/mL? **AND**
   □ No □ Yes
5. Fasting serum phosphorus below the reference range for age? **AND**
   □ No □ Yes
6. Member meets either of the following based on age group: pediatric patients (epiphyseal growth plates are open), at least one of the following:
   a. radiographic evidence of active bone disease (rickets in wrists and/or knees and/or femoral/tibial bowing), OR
   b. documented abnormal growth velocity, **OR**
   c. 1 to 2 years of age without radiographic evidence or abnormal growth velocity; but with confirmed genetic testing or family history, and low fasting serum phosphorus; consider treatment per clinical judgement

   □ No □ Yes

   -OR-
7. Adults and adolescents at final adult height (epiphyseal growth plates are closed) have presence of non-healing fractures? (e.g., visible fracture lines), **AND**
   □ No □ Yes
8. Member does NOT have any of the following: chronic kidney disease (CKD) stage 2 or greater, evidence of tertiary hyperparathyroidism?
   □ No □ Yes

<u>Tumor-Induced Osteomalacia* (TIO)</u>

1. Member is ≥2 years? **AND**
   □ No □ Yes
2. Member has a diagnosis of TIO not amenable to surgical excision of the offending tumor/lesion? **AND**
   □ No □ Yes
3. Serum phosphorus is within or above the normal range for age prior to treatment initiative? **AND,**
   □ No □ Yes
4. Member has no evidence of tertiary hyperparathyroidism
   □ No □ Yes

For Continuation of Therapy, Please Respond to Additional Questions Below:

1. Member has documentation of positive clinical response (defined below), **AND**
   □ No □ Yes
2. Member had an office visit or telephone visit with a specialist within the past 12 months
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information – Please submit chart notes/medical records for the patient that are applicable to this request. Provide any additional supporting information that should be taken into consideration:

____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	Date:
Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility	