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:**