PRIOR AUTHORIZATION REQUEST
Crysvita (burosumab-twza)

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. ☐ Yes ☐ No Is the requested medication prescribed by or in consultation with an endocrinologist or metabolic disease specialist?
2. What is the indication or diagnosis?
   - ☐ X-Linked Hypophosphatemia(XLH) - **please answer questions 3 - 11**
   - ☐ All others (please specify): _____
3. ☐ Yes ☐ No Has the diagnosis of XLH been confirmed by one of the following: DNA testing confirms the presence of mutations in the PHEX gene OR elevated serum fibroblast growth factor 23 (FGF23) levels?
4. ☐ Yes ☐ No Has the patient had a current (within the last 30 days) serum phosphorus level below the reference range for age and gender?
5. ☐ Yes ☐ No Does the patient have the presence of clinical signs and symptoms of the disease?
6. ☐ Yes ☐ No Has the patient tried and failed calcitriol (Rocaltrol) with an oral phosphate agent (K-Phos, K-Phos Neutra), unless contraindicated or clinically significant adverse effects are experienced?
7. ☐ Yes ☐ No Does the dose exceed 90 mg every two weeks (pediatrics) or 90 mg every four weeks (adults)?
8. Is the requested medication for initial therapy or a continuation of therapy?
   - ☐ Initial
   - ☐ Continuation – **please answer questions 9 - 11**
9. ☐ Yes ☐ No Is the member responding positively to therapy as evidenced by both of the following: an increase in serum phosphorus levels from baseline and/or maintenance within the normal range for age and gender, not to exceed the upper limit of that normal range AND a positive clinical response including any of the following: enhanced height velocity, improvement in skeletal deformities, reduction of fractures, reduction of generalized bone pain?

If you have any questions, call: 800-753-2851

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10. ☐ Yes ☐ No Is the requested medication a dose increase?
11. ☐ Yes ☐ No Does the new dose does exceed 90 mg every two weeks (pediatrics) or 90 mg every four weeks (adults) ?

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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