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? ☐ chronic gout ☐ 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

Does your patient have either of the following?
☐ contraindication per FDA label to allopurinol (Zyloprim) AND Uloric (for example, hypersensitivity, concomitant use of azathioprine, mercaptopurine, or theophylline)
☐ contraindication per FDA label to probenecid (for example, hypersensitivity)
☐ neither of the above

(if neither of the above) Did your patient try and fail the following (select all that apply)? Failure is defined as your patient's serum uric acid levels remained at 6 mg/dL or higher.

☐ patient failed either allopurinol (Zyloprim) (dosed at 800mg/day) OR Uloric (dosed at 80mg/day)
☐ patient failed a combination of probenecid with either allopurinol or Uloric
☐ neither of the above

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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