CVS CAREMARK

Fax Referral To: 800-323-2445

Phone: 866-278-6634

Krystexxa® (pegloticase)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION (*Please copy and attach the front and back of insurance and prescription drug card)*

Prescription Card: Name of Insurer: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____
Primary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI** Phone: _____
Secondary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 Code): ☐ Other: _____ • Date of Diagnosis: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

- Patient has a diagnosis of symptomatic chronic gout ☐ Yes ☐ No
- Please provide pre-treatment uric acid level _____
- Patient has tried and had an inadequate response to a 3-month trial of a xanthine oxidase (XO) inhibitor (ie, allopurinol or febuxostat) ☐ Yes ☐ No
  - If yes, was the maximum medically appropriate dose of a XO inhibitor given without adequate response ☐ Yes ☐ No
  - If no, is there a clinical reason for not completing a 3-month trial of a XO inhibitor? ☐ Yes ☐ No
  - Please document reason _____
- Uric acid levels will be monitored prior to each infusion ☐ Yes ☐ No
- If patient is currently receiving Krystexxa, has patient had 2 consecutive uric acid levels above 6 mg/dL ☐ Yes ☐ No
- Patient is at high risk for G6PD deficiency (eg, African or Mediterranean ancestry) ☐ Yes ☐ No
  - If yes, patient has been screened for G6PD deficiency ☐ Yes ☐ No
  - Please provide result of screening _____
- Krystexxa is given in a healthcare setting with access to emergency management for severe anaphylaxis and infusion reactions ☐ Yes ☐ No
- Patient will be premedicated with antihistamines and corticosteroids ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Krystexxa® (pegloticase)				

X _____ X _____

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)