Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
CRYSVITA (burosumab-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 (burosumab-twza)** for **Commercial, Exchange, FEHB (Federal), MD Medicaid,** and **VA Medicaid** plans. 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: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

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: _____

Clinical Criteria:

<u>If treating X-Linked Hypophosphatemia:</u>

1. Is the medication being prescribed by, or in consultation with, a specialist experienced in the treatment of metabolic bone disorders?
   □ No □ Yes

2. Is member ≥6 months of age?
   □ No □ Yes

3. Does member have a diagnosis of X-linked hypophosphatemia (XLH) supported by at least one of the following:
   a. Genetic testing (PHEX mutation) **OR**
   b. Family member with X-linked inheritance **OR**
   c. Serum fibroblast growth factor 23 (FGF23) level >30 pg/mL
   □ No □ Yes

4. Is the fasting serum phosphorus below the reference range for age?
   □ No □ Yes

5. Does the member meet either of the following based on age group:
   a. Pediatric patients (epiphyseal growth plates are open), with at least one of the following:
      - Radiographic evidence of active bone disease (rickets in wrists and/or knees and/or femoral/tibial bowing), **OR**
      - Documented abnormal growth velocity, **OR**
      - <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-

   b. Adults and adolescents at final adult height (epiphyseal growth plates are closed) with one of the following:
      - Presence of non-healing fractures (e.g., visible fracture lines), **OR**
      - May consider treatment if persistent symptoms (e.g., limited mobility, musculoskeletal pain) of XLH and inadequate response, contraindication, or intolerance to standard treatment with oral phosphate and active vitamin D analogs. Consider deprescribing if no improvement in symptoms after 12 months of treatment.

   □ No □ Yes

6. Does the member have any of the following (therapy will not be approved if so)?
   a. Chronic kidney disease (CKD) stage 2 or greater,
   b. Evidence of tertiary hyperparathyroidism
   □ No □ Yes

<u>If treating Tumor-Induced Osteomalacia (TIO):</u>

1. Is the medication being prescribed by an Endocrinologist or Nephrologist – consultation with an Oncologist may be warranted if receiving or planning to receive chemotherapy for TIO or other malignant tumors?
   □ No □ Yes

2. Is the member ≥2 years?

□ No □ Yes

3. Does the member have a diagnosis of TIO not amenable to surgical excision of the offending tumor/lesion?
   □ No □ Yes

4. Is fasting serum phosphorus <2.5 mg/dL* OR below the normal reference range for age**?
   □ No □ Yes

5. Is corrected serum calcium <10.8 mg/dL* OR below the normal reference range for age**?
   □ No □ Yes

6. Does the patient have elevated serum FGF23 (assay specific)?
   □ No □ Yes

7. Is the ratio of renal tubular maximum phosphate reabsorption rate to glomerular filtration rate (TmP/GFR) <2.5 mg/dL* OR below the normal reference range for age **?
   □ No □ Yes

8. Does the member have any of the following (therapy will not be approved if so)?
   a. Chronic kidney disease (CKD) stage 2 or greater
   b. Evidence of tertiary hyperparathyroidism
   □ No □ Yes

**Reference range for adults*
***For pediatric patients, use age-adjusted value for below normal reference range*

For Continuation of Therapy, please respond to <u>additional questions</u> below. New members who were initiated on therapy outside of Kaiser, who have not been reviewed previously, must meet all above Clinical Criteria.

1. Is there documentation of positive clinical response (defined as an improvement in growth velocity, deformities, fractures, or bone pain)?
   □ No □ Yes

2. Has the member had an office visit or telephone visit with a specialist within the past 12 months?
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____
_____
_____

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

Prescriber Signature:	**Date:**