aetna®

Crysvita® (burosumab-twza) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **Endocrinologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Phone: _____ Fax: _____
Address: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Crysvita (burosumab-twza): Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required for all requests):

☐ Yes ☐ No Does the patient have a documented diagnosis of X-linked hypophosphatemia (XLH)?
→ Please identify how the diagnosis of X-linked hypophosphatemia (XLH) was confirmed:
☐ Confirmed phosphate regulating gene with homology to endopeptidases located on the X chromosome (PHEX) mutation in the patient or a directly related family member:
☐ Patient
→ Please provide the date the testing was completed: ____/____/____
☐ Directly related family member
→ Please select the family member with appropriate X-linked inheritance: ☐ mother ☐ father ☐ sibling ☐ other: _____
Please provide the date the testing was completed: ____/____/____
☐ Serum fibroblast growth factor 23 (FGF23) level greater than 30 pg./mL by Kainos assay
→ Please provide the date the testing was completed: ____/____/____

Please provide the patient's serum phosphorus level: _____
What is the serum phosphorus level based on the patient's age: ☐ Below normal range for age ☐ Within normal range for age ☐ Above normal range for age

☐ Yes ☐ No Will the patient be taking Crysvita (burosumab-twza) with an oral phosphate?
☐ Yes ☐ No Will the patient be taking Crysvita (burosumab-twza) with active vitamin D analogs?
☐ Yes ☐ No Does the patient have severe renal impairment?
☐ Yes ☐ No Does the patient have end stage renal disease?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION ***(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests (clinical documentation required for all requests):

☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?
→ ☐ Yes ☐ No Is the patient medically unstable for infusions at alternate levels of care?

☐ Yes ☐ No Does the patient have a history of any cardiopulmonary conditions?
→ Please provide the description of the condition: _____
☐ Yes ☐ No Does this condition cause an increased risk of severe adverse reactions?

☐ Yes ☐ No Does the patient have documentation of unstable vascular access?

☐ Yes ☐ No Does the patient have physical or cognitive impairments such that home infusion would present an unnecessary health risk?
→ Please explain: _____

☐ Yes ☐ No Is there clinical evidence that the patient has an inability to safely tolerate intravenous volume load (including from unstable renal function)?
→ ☐ Yes ☐ No Is the inability to tolerate intravenous volume load due to unstable renal function?
→ Please document the following: ☐ GFR:_____mL/min/1.73m^2 Date Collected: ____/____/____
☐ BUN:_____mg/dL Date Collected: ____/____/____
☐ Creatinine:_____mg/dL Date Collected: ____/____/____

For Continuation Requests (clinical documentation required for all requests):

☐ Yes ☐ No Has the patient received Crysvita (burosumab-twza) within the past 6 months?
→ ☐ Yes ☐ No Does the patient have a documented severe and/or potentially life threatening adverse event that occurred during or following the previous infusion?
→ ☐ Yes ☐ No Could the adverse reaction be managed through pre-medication in the home or office setting?

H. ACKNOWLEDGEMENT

Request Completed By ***(Signature Required):*** _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.