



Crysvita® (burosumab-twza) Injectable Medication Precertification Request

Page 1 of 2

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

Aetna Precertification Notification

Phone: 1-866-752-7021

FAX: 1-888-267-3277

For Medicare Advantage Part B:

Phone: 1-866-503-0857

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 #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Endocrinologist <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	Dispensing Provider/Pharmacy: Patient Selected choice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Phone: _____ Fax: _____ Address: _____ TIN: _____ PIN: _____
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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 Is this infusion request in an outpatient hospital setting?

Yes No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?

Yes No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?

Yes No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?
Please provide a description of the behavioral issue or impairment: _____

Yes No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the patient's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
Please provide a description of the condition: Cardiovascular: _____
 Respiratory: _____
 Renal: _____
 Other: _____

Yes No Is supporting documentation included with this request?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (Continued) - Required clinical information must be completed in its entirety for all precertification requests.

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

X-Linked hypophosphatemia

Yes No Does the patient have a known pathological PHEX (phosphate regulating gene with homology to endopeptidases located on the X chromosome) mutation confirmed by genetic testing?

→ Yes No Was a known pathological PHEX (phosphate regulating gene with homology to endopeptidases located on the X chromosome) mutation confirmed by genetic testing in a directly related family member with appropriate X-linked inheritance?

→ Yes No Does the patient have a serum fibroblast growth factor 23 (FGF23) level above the upper limit of normal or abnormal for the assay?

Yes No Does the patient have radiographic evidence of rickets or other bone disease attributed to XLH?

FGF23-related hypophosphatemia in tumor induced osteomalacia (TIO)

Yes No Is the patient's disease associated with phosphaturic mesenchymal tumors that cannot be curatively resected or localized?

Yes No Is the patient's FGF23 level above the upper limit of normal or abnormal for the assay?

Yes No Is the patient's fasting serum phosphorus level less than 2.5 mg/dL?

Yes No Is the patient's ratio of renal tubular maximum reabsorption rate of phosphate to glomerular filtration rate (TmP/GFR) less than 2.5 mg/dL?

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

Yes No Is the patient currently receiving the requesting medication through samples or a manufacture's patient assistance program?

Yes No Is the patient experiencing a benefit from therapy with the requested medication as evidenced by disease stability or disease improvement (e.g., increase or normalization in serum phosphate, improvement in the bone and joint pain, reduction in fractures, improvement in skeletal deformities)?

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.