



**Pegloticase (Krystexxa®) Injectable Medication  
Precertification Request**

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

**Please indicate:**  Start of treatment  Continuation of therapy **Today's date:** \_\_\_\_\_ **Date needed:** \_\_\_\_\_

**Ship to:**  Doctor's office  Patient  Other: \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Dispensing Provider:**  Aetna Specialty Pharmacy® or  Other: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ **TIN:** \_\_\_\_\_ **PIN:** \_\_\_\_\_

**Precertification Requested By:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**A. PATIENT INFORMATION**

|  |             |   |             |
|--|-------------|---|-------------|
| First Name:                                    |             | Last Name:                                |             |
| Address:                                       |             | City:                                     | State: ZIP: |
| Home Phone:                                    | Work Phone: | Cell Phone:                               |             |
| DOB:   | Allergies:  | Email:                                    |             |
| Patient Current Weight: _____ lbs or _____ kgs |             | Patient Height: _____ inches or _____ cms |             |

**B. INSURANCE INFORMATION**

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

**C. PRESCRIBER INFORMATION**

|                 |      |                      |        |  |       |
|-----------------|------|----------------------|--------|--|-------|
| First Name:     |      | Last Name:           |        | <i>(Circle one):</i> M.D. D.O. N.P. P.A. |       |
| Address:        |      | City:                | State: | ZIP:                                     |       |
| Phone:          | Fax: | St. Lic. #:          | NPI #: | DEA #:                                   | UPIN: |
| Provider Email: |      | Office Contact Name: |        | Phone:                                   |       |

**Specialty (Circle one):** Orthopedics Rheumatologist Other: \_\_\_\_\_

**D. DIAGNOSIS INFORMATION**

Primary ICD-9: \_\_\_\_\_  
Secondary ICD-9: \_\_\_\_\_ Other ICD-9 Code: \_\_\_\_\_

**E. CLINICAL INFORMATION**

Yes  No Did the patient have at least 3 gout flares in the previous 18 months that were inadequately controlled by colchicine and non-steroidal, anti-inflammatory drugs?

Yes  No Did the patient have at least 1 gout tophus or gouty arthritis?

**If you answered "Yes" to either question above please answer the following:**

Yes  No Did the patient fail to normalize serum uric acid to less than 6mg/dL after 3 months of maximum medically appropriate dose of xanthine oxidase inhibitors?

Yes  No Are xanthine oxidase inhibitors contraindicated?

**F. PRESCRIPTION INFORMATION – To be completed only if Aetna Specialty Pharmacy is Dispensing Provider**

| MEDICATION   | STRENGTH | DIRECTIONS                       | QUANTITY | REFILLS |
|--|----------|----------------------------------|----------|---------|
| Krystexxa 8mg<br>CPB # 0810  |          | Infuse _____ mg IV every 2 weeks |          |         |
| <input type="checkbox"/> NS 0.9% 250ml<br><b>OR</b><br><input type="checkbox"/> NS 0.45% 250ml |          | For IV infusion                  |          |         |

**Premedication with antihistamine and corticosteroid recommended.**  
**If ordering through ASRx, please specify below the drug name, strength and directions.**

|                  |  |  |  |  |
|------------------|--|--|--|--|
| (Antihistamine)  |  |  |  |  |
| (Corticosteroid) |  |  |  |  |

\*If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.  
\*If the prescriber is providing the drug, the provider must verify benefits.

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
*(Required by law if Aetna Specialty Pharmacy is the dispensing pharmacy.)*

**Interchange is mandated unless practitioner writes the words "BRAND MEDICALLY NECESSARY" in this space:** \_\_\_\_\_