



Crysvita® (burosumab-twza) Injectable Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-866-752-7021 (TTY: 711)
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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): Endocrinologist 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: _____

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):	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this infusion request in an outpatient hospital setting?
<input type="checkbox"/> Yes <input type="checkbox"/> 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, or other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?
<input type="checkbox"/> Yes <input type="checkbox"/> 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: _____
<input type="checkbox"/> Yes <input type="checkbox"/> 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 patient 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: <input type="checkbox"/> Cardiovascular: _____ <input type="checkbox"/> Respiratory: _____ <input type="checkbox"/> Renal: _____ <input type="checkbox"/> Other: _____

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FAX: [1-888-267-3277](tel:1-888-267-3277)

For Medicare Advantage Part B:
Please Use Medicare Request Form

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 including lab work):

X-Linked hypophosphatemia (XLH)

- Yes No Does the patient have a known PHEX (phosphate regulating gene with homology to endopeptidases located on the X chromosome) mutation confirmed by genetic testing?
 ↳ Yes No Was a known 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 Is the patient's 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 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 Are the patient's fasting serum phosphorus levels 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 including lab work):

- Yes No Is the patient currently receiving the requested medication through samples or a manufacture's patient assistance program?
 Yes No Is the patient experiencing 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 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.