Korsuva® (difelikefalin injection) Medication Precertification Request

(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:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms		Allergies:	

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 Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Nephrologist** ☐ **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 ☐ Other
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Korsuva (difelikefalin injection) 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):

☐ Yes ☐ No Does the patient have a diagnosis of pruritus?
☐ Yes ☐ No Will the requested drug be used for the treatment of moderate-to-severe pruritus?
☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a nephrologist?
☐ Yes ☐ No Is the patient on peritoneal dialysis?
☐ Yes ☐ No Is the patient currently undergoing hemodialysis (HD)?
☐ Yes ☐ No Does the patient have pruritus associated with chronic kidney disease (CKD) (also known as uremic pruritus) supported by a baseline scoring system (e.g., Worst Itching Intensity Numerical Rating Scale [WI-NRS], visual analog scale [VAS]/numeric rating scale [NRS])?
☐ Yes ☐ No Is the patient's pruritus associated with non-uremic causes (e.g., primary dermatologic conditions [e.g., drug-induced hypersensitivity, allergies, dermatitis, psoriasis])?
→ ☐ Yes ☐ No Is the patient's pruritus associated with systemic conditions (e.g., liver disease, malignancy/lymphoma, post-herpetic neuralgia, HIV)?
☐ Yes ☐ No Does the patient's pruritus occur only during the dialysis session?
☐ Yes ☐ No Has the patient tried and failed other pruritus treatments (e.g., antihistamines, gabapentin, pregabalin, topical emollients/analgesics)?
→ ☐ Yes ☐ No Does the patient have a contraindication to other pruritus treatments (e.g., antihistamines, gabapentin, pregabalin, topical emollients/analgesics)?
☐ Yes ☐ No Will the dosage exceed 0.5 mcg/kg per hemodialysis treatment?
☐ Yes ☐ No Will the dosage exceed three doses per week?

For Continuation Requests (clinical documentation required):

☐ Yes ☐ No Has the patient demonstrated a positive clinical response in pruritus symptoms (e.g., improvement of at least 4 points from baseline on the Worst Itching Intensity Numerical Rating Scale [WI-NRS])?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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.