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WEB: [DSS Medicaid Prior Authorizations](#) | EMAIL : DSSMedicaidpa@state.sd.us

KRYSTEXXA PRIOR AUTHORIZATION REQUEST FORM

This form **MUST BE** submitted with medical records to support services

Date:		
RECEIPIENT INFORMATION		
Medicaid ID:	Date of Birth:	Sex: M F
Last Name:		First Name:
GENERAL INFORMATION		
First Date of Service:		Last Date of Service:
Primary Diagnosis Code:		HCPC Code:
Drug Name:		Dose & Frequency:
Hospitalizations/Treatments/Medications Used in the last 6 months:		
POINT OF CONTACT		
Name and Title:		
Email:	Phone:	Fax:
<small><i>Note: The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed point of contact.</i></small>		
REFERRING PROVIDER INFORMATION		
Name:		
NPI #:		Taxonomy:
Phone:		Fax:
SERVICING PROVIDER INFORMATION		
Name:		
Address:		
NPI #:		Taxonomy:
Phone:		Fax:

CRITERIA		
Medical records to support use of product are submitted		
Initial Therapy (check one)	Yes	No
	Individual has a diagnosis of chronic gout based on one of the following: <ul style="list-style-type: none"> • Three or more gout flares within the previous 18 months • One or more tophus present • History of chronic gouty arthropathy, defined clinically or radiographically as joint damage due to gout 	
	Individual has a failure, contraindication or intolerance to both allopurinol and febuxostat	
	Individual has a failure, contraindication or intolerance to probenecid	
	Failure of previous trials must be documented by both of the following: <ul style="list-style-type: none"> • Serum uric acid level >6mg/dl after at least a 90 day drug trial • At least 2 gout flares within the past 12 months or at least one tophus deposit (with at least one of the flares occurring after the 90 day drug trial of allopurinol and/or febuxostat) 	
	Therapy is not prescribed concurrently with other urate lowering therapies	
	Individual is ≥18 years of age	
Continuation of Therapy (check one)	Yes	No
	Individual has shown clinically significant improvement in signs and symptoms of the disease as indicated a reduction in serum uric acid level and one of the following: <ul style="list-style-type: none"> • Reduction in number of gout flares • Tophus resolution • Reduction in joint pain 	
PHYSICIAN SIGNATURE – PROVIDER ONLY		
This form <u>must be</u> signed by a provider		
	I certify that the information given in this form is a true and accurate medical indication for the required product	
Name & Title (Printed):		Specialty:
Signature:		