FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

Crysvita® Coverage Determination Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type of Coverage Determination Requested:

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

Select the diagnosis below:

❑ X linked hypophosphatemia

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Does the patient have documented phosphate regulating gene with homology to endopeptidases located on the X chromosome (PHEX)? ❑ **Yes** ❑ **No**

Does the patient have serum fibroblast growth factor 23 (FGF23) level greater than 30 pg/mL? ❑ **Yes** ❑ **No**

Is there documentation the patient has classic clinical features of X linked hypophosphatemia (e.g., rickets, growth abnormalities [short stature or lower extremity bowing], bone pain, bone fractures)? ❑ **Yes** ❑ **No**

Does the patient have fasting serum phosphorus below the normal range for age? ❑ **Yes** ❑ **No**

Will the patient use oral phosphate or active vitamin D analogs within one week of treatment initiation? ❑ **Yes** ❑ **No**

Does the patient have severe renal impairment or end-stage renal disease? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following:

Does the patient have normalized serum phosphorus levels during therapy? ❑ **Yes** ❑ **No**

Select if the patient has documentation of improvement as assessed by the following:

- ❑ Decrease in bone pain
- ❑ Enhanced mobility
- ❑ Improvement in osteomalacia
- ❑ Improvement in fracture healing
- ❑ Enhanced height velocity
- ❑ Improvement in lower extremity bowing and associated abnormalities
- ❑ Improved walking ability
- ❑ Radiographic evidence of improvements of rickets/ osteomalacia/ epiphyseal healing

Will the patient use oral phosphate or active vitamin D analogs within one week of treatment initiation? ❑ **Yes** ❑ **No**

Does the patient have serum phosphate levels within or above normal range for age (prior to reinitiating therapy)? ❑ **Yes** ❑ **No**

Does the patient have severe renal impairment or end-stage renal disease? ❑ **Yes** ❑ **No**

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.