



Fax completed form to: (855) 840-1678  
 If this is an URGENT request, please call (800) 882-4462  
 (800.88.CIGNA)

# Crysvita (burosumab-twza)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:		* Date of Birth:
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		
<b>Urgency:</b> <input type="checkbox"/> Standard <input type="checkbox"/> Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)					
<b>Medication requested:</b> <input type="checkbox"/> Crysvita 10mg/ml <input type="checkbox"/> Crysvita 20mg/ml <input type="checkbox"/> Crysvita 30mg/ml  Directions for use and Quantity: _____ ICD10: _____  Duration of therapy: _____ Patient's current weight: _____					
Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>					
<b>Where will this medication be obtained?</b> <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Hospital - In patient <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Other (please specify): _____  CPT Code(s): _____  <div style="float: right;"> <input type="checkbox"/> Ambulatory Infusion Center  <input type="checkbox"/> Home Health / Home Infusion vendor (name): _____  <input type="checkbox"/> Physician's office stock (billing on a medical claim form)  <b>**Cigna's nationally preferred specialty pharmacy</b> </div>					
<b>Facility and/or doctor dispensing and administering medication:</b> Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____					
<b>Where will this drug be administered?</b> <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Other (please specify): _____  <p style="text-align: center;"><b>NOTE:</b> Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.</p>					
Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No (provide medical necessity rationale):</span>					
<b>Diagnosis related to use:</b> <input type="checkbox"/> Epidermal Nevus Syndrome (including Cutaneous Skeletal Hypophosphatemia Syndrome) <input type="checkbox"/> Tumor-Induced Osteomalacia <input type="checkbox"/> X-linked hypophosphatemia <input type="checkbox"/> All other indications or diagnoses					

**Clinical Information:**

Does the patient have Chronic Kidney Disease, Severe Renal Impairment or End Stage Renal Disease?  Yes  No

Is the patient currently receiving the requested medication?  Yes  No

**if X-linked hypophosphatemia:**

(if currently receiving) Is the patient continuing to derive benefit from the requested medication as determined by the prescriber? Note: Examples of a response to Crysvida therapy are increased phosphorus levels, radiographic improvement in deformities, healing of fractures/pseudofractures, reduction in the incidence of new fractures/pseudofractures.  Yes  No

(if initial therapy) Is the requested medication being prescribed by or in consultation with an endocrinologist or nephrologist?  Yes  No

(if initial therapy) Is documentation being provided that the patient has had a baseline serum phosphorus level that was below the normal range for age? Note: "Baseline" is defined as prior to receiving any X-linked hypophosphatemia treatment, such as Crysvida, oral phosphate, or vitamin D therapy. PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information  Yes  No

(if initial therapy) Is documentation being provided that the patient has had a baseline tubular reabsorption of phosphate corrected for glomerular filtration rate (TmP/GFR) that was below the normal range for age and gender? Note: "Baseline" is defined as prior to receiving any X-linked hypophosphatemia treatment, such as Crysvida, oral phosphate, or vitamin D therapy. PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information.  Yes  No

(if no) Is documentation being provided that the patient has had a genetic test confirming the diagnosis of X-linked hypophosphatemia via identification of a PHEX pathogenic variant? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information.  Yes  No

(if initial therapy, 18 years and older) Does the patient have fractures and/or pseudofractures?  Yes  No

(if no) According to the prescriber, is the patient currently exhibiting one or more signs or symptoms of X-linked hypophosphatemia (XLH)? Note: Examples of signs and symptoms of XLH in patients 18 years of age or older include bone and joint pain, stiffness, muscle weakness, impaired mobility, or biochemical and/or clinical signs of osteomalacia.  Yes  No

(if yes) Has the patient tried oral phosphate and calcitriol therapy?  Yes  No

(if no) According to the prescriber, does the patient have a contraindication to oral phosphate therapy, calcitriol therapy, or both?  Yes  No

**If Tumor-Induced Osteomalacia:**

(if currently receiving) Is the patient continuing to derive benefit from the requested medication as determined by the prescriber? Note: Examples of a response to Crysvida therapy are increased phosphorus levels, decreased symptoms of bone pain and/or muscle weakness, and increased mobility.  Yes  No

(if initial therapy) Is the requested medication being prescribed by or in consultation with an endocrinologist or nephrologist?  Yes  No

(if initial therapy) Does the patient have a mesenchymal tumor that cannot be curatively resected or identified/localized?  Yes  No

((if initial therapy) According to the prescriber, is the patient currently exhibiting one or more signs or symptoms of tumor-induced osteomalacia? Note: Examples of signs and symptoms of TIO include bone pain, impaired mobility, muscle weakness, and fatigue.  Yes  No

(if initial therapy) Is documentation being provided that the patient has had a baseline serum phosphorus level that was below the normal range for age? Note: "Baseline" is defined as prior to receiving any tumor-induced osteomalacia treatment, such as Crysvida, oral phosphate, or vitamin D therapy. PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information.  Yes  No

(if initial therapy) Is documentation being provided that the patient has had a baseline tubular reabsorption of phosphate corrected for glomerular filtration rate (TmP/GFR) that was below the normal range for age and gender? Note: "Baseline" is defined as prior to receiving any tumor-induced osteomalacia treatment, such as Crysvida, oral phosphate, or vitamin D therapy. PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information.  Yes  No

(if initial therapy) Is documentation being provided that the patient has tried oral phosphate and calcitriol therapy? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information.  Yes  No

(if no) Is documentation being provided that the patient has a contraindication to oral phosphate therapy, calcitriol therapy, or both? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information.  Yes  No

**Additional Pertinent Information:**

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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