



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit go.covermymeds.com/OptumRx to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Crysvita® Prior Authorization Request Form (Page 1 of 2)

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information <small>(required)</small>					
<p>Continuation of therapy: Is this a continuation of prior therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" to the above question, please submit documentation (e.g., medical records, chart notes, pharmacy claims) or provide the dates, duration, and previous regimen used below: (REQUIRED)</p> <hr/>					
<p>Select the diagnosis below: <input type="checkbox"/> X-linked hypophosphatemia <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>					
<p>Clinical Information: Select if Crysvita is prescribed by one of the following specialists: <input type="checkbox"/> Endocrinologist <input type="checkbox"/> Nephrologist <input type="checkbox"/> PCP (primary care physician) upon consultation with either specialist listed above Is there documentation of patient's genetic mutation? <input type="checkbox"/> Yes <input type="checkbox"/> No Is there presence of contraindications or absolute drug interactions with existing therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No For adults (18 years of age and older), does the patient have continued bone pain and limited mobility after failure of vitamin D, phosphates, and calcimimetic? <input type="checkbox"/> Yes <input type="checkbox"/> No For children (under 18 years of age), does the patient have presence of Rickets on radiographical studies after failure of vitamin D, phosphate, and calcimimetics? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
<p>Reauthorization: For adults (18 years of age and older), is there documentation of medical need as established by the prescribing provider? <input type="checkbox"/> Yes <input type="checkbox"/> No For children (under 18 years of age), select if there is documentation of the following: <input type="checkbox"/> Enhanced height velocity <input type="checkbox"/> Lower extremity bowing and associated abnormalities <input type="checkbox"/> Radiographical evidence of epiphyseal healing</p>					

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

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Crysvita[®] Prior Authorization Request Form (Page 2 of 2)

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Quantity Limit Requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- Titration or loading dose purposes
- Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- Requested strength/dose is not commercially available
- Other: _____

For continuation of existing therapy, also answer the following:

Would sudden discontinuation of the dose trigger withdrawal symptoms? Yes No

Would discontinuation of the dose be unsafe for the patient and their condition may worsen or exacerbate? Yes No

Is the prescribing provider attempting to taper or reduce the dose necessary? Yes No

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.

For urgent or expedited requests please call 1-855-297-2870.

This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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