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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

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
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 (required)					
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 (required)					
Select the diagnosis below:					
<input type="checkbox"/> X-linked hypophosphatemia					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information:					
Is Crysvita prescribed by or in consultation with an endocrinologist or specialist experienced in the treatment of inborn errors of metabolism? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Select if the patient has the following, indicating the patient is a candidate for pharmacologic therapy:					
<input type="checkbox"/> Spontaneous insufficiency fractures					
<input type="checkbox"/> Pending orthopedic procedures (e.g., joint replacement)					
<input type="checkbox"/> Biochemical evidence of osteomalacia (i.e., elevated serum alkaline phosphatase)					
<input type="checkbox"/> Disabling skeletal pain					
Does the patient have trial and failure, contraindication, or intolerance to conventional treatment with phosphate- and vitamin D analog-based therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Reauthorization:					
Is there documentation the patient has had a positive clinical response to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> 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 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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.**
Office use only: Crysvita_Comm_2018Aug-W