Krystexxa
Medicare Part B – Prior Authorization

PART B PRIOR AUTHORIZATION CRITERIA FOR APPROVAL

Krystexxa will be approved when ALL of the following are met:

1. The requested medication is being used for ONE of the following:
    A. An FDA approved indication
    OR
    B. An indication in CMS approved compendia
    AND
2. The patient does NOT have any FDA labeled contraindications to the requested medication
    AND
3. The requested quantity (dose) is within FDA labeled dosing or supported in compendia for the requested indication

Length of Approval: up to 12 months

NOTES:

- Length of approval may be shorter due to provider network participation status.
- LCD/NCD criteria review completed, if applicable, in addition to the Plan's Medicare Part B criteria.