Jefferson Health Plans

MEDICAID / CHIP

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Crysvita - Non-PDL

Phone: 866-841-7659 **Fax back to: 866-240-3712**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
Member ID Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Phone Number:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is the medication prescribed by or in consultation with a geneticist, nephrologist, oncologist, rheumatologist, endocrinologist or other specialist experienced in the treatment of patients with metabolic bone disease?

☐ Yes ☐ No

Q2. Is this a request for renewal? If YES, go to 3. If NO, go to 5.

☐ Yes ☐ No

Q3. Does the patient tolerate the medication without significant or serious side effects (must attach documentation)?

☐ Yes ☐ No

Q4. Has the patient had an improvement in symptoms from baseline (must attach documentation)?

☐ Yes ☐ No

Q5. Does the patient have a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

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☐ Yes ☐ No

Q6. Is the patient age appropriate according to the FDA approved package labeling?

☐ Yes ☐ No

Q7. Is the patient prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q8. Does the patient have a baseline (before treatment) fasting serum phosphate level that is below the reference range for age?

☐ Yes ☐ No

Q9. Does the patient have laboratory evidence of renal phosphate wasting (i.e., low percent tubular reabsorption of phosphate [%TRP] and/or low fasting tubular maximum reabsorption of phosphate to glomerular filtration rate [TmP/GFR]) ?

☐ Yes ☐ No

Q10. Does the patient have a baseline (before treatment) fibroblast growth factor 23 (FGF23) level that is normal or above the assay-specific reference range for age?

☐ Yes ☐ No

Q11. Is the drug being used for the treatment of X-linked hypophosphatemia? If YES, go to 12. If NO, go to 14.

☐ Yes ☐ No

Q12. For the treatment of X-linked hypophosphatemia (XLH), has a diagnosis of XLH confirmed by at least one of the following:

☐ Confirmed PHEX gene mutation
☐ Positive family history of XLH

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☐ Presence of typical clinical features of XLH (e.g., abnormal gait, lower limb deformity, decreased growth velocity, etc. in children; short stature, osteomalacia, bone pain, osteoarthritis, pseudofractures, stiffness, enthesopathies, poor dental condition, etc. in adults).

Q13. For the treatment of X-linked hypophosphatemia (XLH), has at least one of the following:

☐ Has open epiphyses

☐ Is experiencing clinical signs and/or symptoms of XLH (e.g., limited mobility, musculoskeletal pain and/or stiffness, bone fractures or pseudofractures, decreased physical function, renal calculi, etc.)

Q14. For the treatment of tumor-induced osteomalacia (TIO), has a diagnosis of active TIO confirmed by at least one of the following:

☐ Identification and localization of the underlying tumor that is unresectable or pending resection

☐ Other causes of genetic and acquired renal phosphate-wasting disorders have been reasonably ruled out

Q15. Additional Information:

_____ _____

Prescriber Signature Date

v2026-06