Pharmacy Drug Policy & Procedure

Policy Name:	Krystexxa (pegloticase)	Policy#:	2418P

Purpose of the Policy

The purpose of this policy is to define coverage criteria for Krystexxa (pegloticase).

Statement of the Policy

Health Alliance Medical Plans will approve the use of Krystexxa (pegloticase) under the specialty medical benefit if the following criteria are met.

Criteria

1. Criteria for coverage of Krystexxa

1.1 Diagnosis of symptomatic chronic gout

1.2 Documentation that the member is not at high risk for a G6PD deficiency (a genetic disorder that causes red blood cells to break down prematurely)
- If the member is at high risk for G6PD deficiency, submission of lab results which indicate no G6PD deficiency

1.3 Documented 3-month trial and failure, intolerance, or contraindication a xanthine oxidase inhibitor:
- Allopurinol or febuxostat

1.4 Documentation to support Krystexxa will be taken with methotrexate unless contraindicated
- This requirement can be bypassed if patient is already stabilized on another immunosuppressant due to this increased risk of significant immunosuppression

2. Approval Time

2.1 Initial Approval: 12 months

2.2 Reapproval: 12 months with documentation that the member has not had 2 consecutive uric acid levels above 6mg/dL

CPT Codes	
HCPCS Codes	
J2507	Injection, pegloticase, 1mg

References

1. Krystexxa (pegloticase) [prescribing information]. Deerfield, IL: Horizon Therapeutics USA Inc; July 2022.
2. Hamburger M, Baraf HS, Adamson TC, et al. 2011 Recommendations for the diagnosis and management of gout and hyperuricemia. Postgrad Med. 2011;123(6 Suppl 1):3–36.
3. FitzGerald JD, Dalbeth N, Mikuls T, et al. 2020 American College of Rheumatology guideline for the management of gout. Arthritis Care Res (Hoboken). 2020;72(6):744-760.
4. Richette P, Doherty M, Pascual E, et al. 2016 updated EULAR evidence-based recommendations for the

management of gout. Ann Rheum Dis. 2017;76(1):29-42.

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