Krystexxa (pegloticase)
PAM – 009

Iowa Medicaid Program	Prior Authorization	**Effective Date**	08/20/2011
Revision Number	12	**Last Reviewed**	04/18/2025
Reviewed By	Medicaid Medical Director	**Next Review**	04/17/2026
Approved By	Medicaid Clinical Advisory Committee	**Approved Date**	03/21/2018

Overview

Medication: [1]	pegloticase
Brand Name:	Krystexxa®
Pharmacologic Category:	Enzyme, urate-oxidase (recombinant)
FDA-Approved Indication(s):	PEGylated uric acid specific enzyme indicated for the treatment of chronic gout in adult patients refractory to conventional therapy. ▶ Limitations of Use: Krystexxa® is not recommended for the treatment of asymptomatic hyperuricemia.
How Supplied:	Single-dose glass vial containing 8 mg of Krystexxa® in 1 mL volume
Dosage and Administration:	Intravenous infusion: 8 mg once every 2 weeks
Benefit Category:	Medical

WARNING: ANAPHYLAXIS AND INFUSION REACTIONS, G6PD DEFICIENCY ASSOCIATED HEMOLYSIS & METHEMOGLOBINEMIA

- Anaphylaxis and infusion reactions have been reported to occur during and after administration of Krystexxa®.
- Anaphylaxis may occur with any infusion and generally manifests within 2 hours of the infusion. However, delayed hypersensitivity reactions have also been reported.
- Krystexxa® should be administered in healthcare settings and by healthcare providers prepared to manage anaphylaxis and infusion reactions.
- Premedicate with antihistamines and corticosteroids and closely monitor for anaphylaxis for an appropriate period of time after administration of Krystexxa®.
- Monitor serum uric acid levels prior to each infusion and discontinue treatment if levels increase to above 6 mg/dL, particularly when 2 consecutive levels above 6 mg/dL are observed.
- Screen patients at risk for G6PD deficiency prior to starting Krystexxa®. Hemolysis and methemoglobinemia have been reported with Krystexxa® in patients with G6PD deficiency. Krystexxa® is contraindicated in patients with G6PD deficiency.

Descriptive Narrative

Krystexxa® is a recombinant porcine-like uricase for the treatment of chronic gout, which converts uric acid to allantoin enzymatically. It is pegylated to increase the elimination half-life from 8 hours to 10-12 days and decrease the immunogenicity of the foreign uricase protein. Krystexxa® carries a black box warning indicating that it should not be administered to patients with a glucose-6-phosphate dehydrogenase (G6PD) deficiency, as life-threatening hemolytic reactions and methemoglobinemia have been reported in patients with this deficiency who were treated with Krystexxa®. Patients of African or Mediterranean ancestry should be screened for G6PD deficiency before starting treatment. Infusion reactions, including anaphylaxis, are possible. Administration of this drug should be done in an outpatient hospital, clinic, or physician office setting to assure capability of providers to expeditiously address any untoward side-effects, such as anaphylaxis.

Guidelines

The American College of Rheumatology released updated guidelines in 2020 for the management of gout. The strength of each recommendation was rated as either:

1. *Strong* (recommendation reflects decisions supported by moderate or high certainty of evidence where the benefits consistently outweigh the risks, and, with only rare exceptions, an informed patient and his or her provider would be expected to reach the same decision); OR
2. *Conditional* (recommendation reflects scenarios for which the benefits and risks may be more closely balanced and/or only low certainty of evidence or no data are available).

Recommendations for choice of initial urate-lowering therapy in patients with gout include the following:

1. Treatment with allopurinol as the preferred first-line agent is *strongly recommended* for all patients, including those with moderate-to-severe chronic kidney disease (CKD) (stage $\geq$ 3).
2. The choice of either allopurinol or febuxostat over probenecid is *strongly recommended* in patients with moderate-to-severe CKD (stage $\geq$ 3).
3. The choice of pegloticase as a first-line therapy is *strongly recommended* ***against.***
4. Starting treatment with low-dose allopurinol ($\leq$ 100 mg/day and lower in patients with CKD [stage $\geq$ 3]) and febuxostat ($\leq$ 40 mg/day) with subsequent dose titration over starting at a higher dose is *strongly recommended*.

5. Starting treatment with low-dose probenecid (500 mg once to twice daily) with subsequent dose titration over starting at a higher dose is *conditionally recommended*.
6. Administering concomitant anti-inflammatory prophylaxis therapy (e.g., colchicine, non-steroidal anti-inflammatory drugs [NSAIDS], prednisone/ prednisolone) over no anti-inflammatory therapy is *strongly recommended*.
7. Continuing concomitant anti-inflammatory prophylaxis therapy for 3 to 6 months, with ongoing evaluation and continued prophylaxis as needed if the patient continues to experience gout flares, is *strongly recommended*.[2]

Criteria

Prior authorization is required.

Krystexxa® is considered medically necessary when **ALL** of the following are met:

1. Diagnosis of *symptomatic* gout as defined by (a, b, or c) (Krystexxa® is not recommended for the treatment of asymptomatic hyperuricemia):
   a. At least three gout flares in the previous 18 months; **OR**
   b. History of chronic gouty arthritis; **OR**
   c. At least one gout tophus; **AND**
2. Member is 18 years of age or older; **AND**
3. Failure to normalize uric acid to less than 6 mg/dL with allopurinol and febuxostat at maximally indicated doses, each used for at least 3 months unless clinically significant adverse effects are experienced or both are contraindicated (maximum indicated dose for allopurinol is 800 mg daily, and for febuxostat is 80 mg daily); **AND**
4. Failure of one uricosuric agent (e.g., probenecid) at a maximally indicated dose, in combination with allopurinol or febuxostat unless clinically significant adverse effects are experienced or all are contraindicated (maximum indicated dose for probenecid is 2,000 mg daily); **AND**
5. Member has a baseline serum uric acid level of $\geq$ 6 mg/dL prior to starting therapy with Krystexxa®; **AND**
6. Documentation that oral urate-lowering agents (e.g., allopurinol, febuxostat, probenecid) will be discontinued prior to initiating therapy with Krystexxa®; **AND**
7. Prescribed by, or in consultation with, a rheumatologist or nephrologist; **AND**
8. Dosage does not exceed the maximum allowable dose: 8 mg every 2 weeks.

Krystexxa® is considered medically necessary for continuation of therapy when **ALL** of the following are met:

1. Member is currently receiving medication through the Iowa Medicaid benefit or has previously met initial approval criteria; **AND**
2. Documentation of positive clinical response to therapy (including but not limited to a decrease in plasma uric acid levels, gout flare reduction, tophus resolution, reduction in joint pain); **AND**
3. Laboratory results document that the member's last two uric acid levels (drawn prior to infusion) did not exceed 6 mg/dL; **AND**
4. Prescribed by, or in consultation with, a rheumatologist or nephrologist; **AND**
5. Dosage does not exceed the maximum allowable dose: 8 mg every 2 weeks.

Approval Duration and Quantity Limits

	Initial Authorization	Subsequent Authorization(s)
Approval Duration	6 months	12 months
Quantity Limits	8 mg every 2 weeks	8 mg every 2 weeks

Coding and Product Information

The following list(s) of codes and product information are provided for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment, nor does the exclusion of a code imply that its association to the HCPCS code is inappropriate.

HCPCS	Description
J2507	Injection, pegloticase, 1 mg

ICD-10	Description
M1A	Chronic gout
M1A.9	Chronic gout, unspecified

NDC (Strength)	Labeler	Dosage	Pkg Size	Pkg Qty	Units/ Pkg
75987-0080-10 (single-dose vial, 8 mg/mL)	Horizon Therapeutics USA, Inc. (75987)	1 mg	1	EA	8

Compliance

1. Should conflict exist between the policy and applicable statute, the applicable statute shall supersede.
2. Federal and State law, as well as contract language, including definitions and specific contract provisions or exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage.

3. Medical technology is constantly evolving, and Iowa Medicaid reserves the right to review and update medical policy on an annual or as-needed basis.

Medical necessity guidelines have been developed for determining coverage for member benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. Medical necessity guidelines are developed for selected physician-administered medications found to be safe and proven to be effective in a limited, defined population or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Criteria are revised and updated annually, or more frequently if new evidence becomes available that suggests needed revisions.

References

[1] Krystexxa® prescribing information (11/2022). Horizon Therapeutics USA, Inc.: Deerfield, IL. Available online: www.krystexxahcp.com. Accessed March 3, 2025.

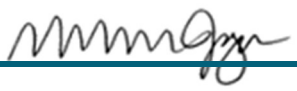
[2] FitzGerald JD, et al. 2020 American College of Rheumatology Guideline for the Management of Gout. Arthritis Care Res (Hoboken). 2020 Jun;72(6):744-760. doi: 10.1002/acr.24180. Epub 2020 May 11. Erratum in: Arthritis Care Res (Hoboken). 2020 Aug;72(8):1187. Erratum in: Arthritis Care Res (Hoboken). 2021 Mar;73(3):458. PMID: 32391934.

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

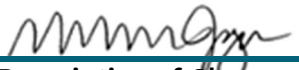
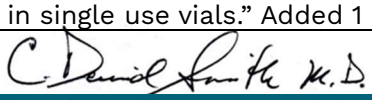
Criteria Change History

Change Date	Changed By	Description of Change	Version
[mm/dd/yyyy]	CAC		
Signature			

Change Date	Changed By	Description of Change	Version
[mm/dd/yyyy]	CAC		
Signature			

Change Date	Changed By	Description of Change	Version
04/18/2025	CAC	Annual review. No changes.	12
Signature William (Bill) Jagiello, DO			

Criteria Change History *(continued)*

Change Date	Changed By	Description of Change	Version
04/19/2024	CAC	Annual review. No changes.	11
Signature			
William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
07/21/2023	CAC	Annual review. Added to Overview section: list of Warnings from prescribing information.	10
Signature			
William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
04/15/2022	CAC	Annual review.	9
Signature			
William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
04/16/2021	CAC	Annual review. Minor formatting changes.	8
Signature			
William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
01/19/2018	CAC	Under Criterion #1 added “8 mg IV every 2 weeks provided in single use vials.” Added 1 8) “Age must be over 18.”	7
Signature			
C. David Smith, MD			
Change Date	**Changed By**	**Description of Change**	**Version**
05/01/2017	Policy	Added settings for administration of this medication to introductory paragraph.	6
Signature			
Change Date	**Changed By**	**Description of Change**	**Version**
01/20/2017	Medical Director	Added information under description. Added Criterion #1 3), 7)., c and d.	5
Signature			
Change Date	**Changed By**	**Description of Change**	**Version**
07/15/2016	Medical Director	Added description above Criteria.	4
Signature			
Change Date	**Changed By**	**Description of Change**	**Version**
07/17/2015	CAC	Added last paragraph in References.	3
Signature			
Change Date	**Changed By**	**Description of Change**	**Version**
07/14/2015	Medical Director	Added prescribing information reference.	2
Signature			
Change Date	**Changed By**	**Description of Change**	**Version**
07/18/2014	CAC	Under Criteria – removed treatment failure of at least two NSAIDs.	1
Signature			

CAC = Medicaid Clinical Advisory Committee