Prior Authorization Request Form for Antihyperuricemics

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)		
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Requests for non-preferred Xanthine Oxidase Inhibitor: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Xanthine Oxidase Inhibitor? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No	Medications Taken (start and end date and dose):_____ _____ _____
Requests for non-preferred single-ingredient Colchicine: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred single-ingredient Colchicine? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No	Medications Taken (start and end date and dose):_____ _____ _____
Requests for non-preferred Antihyperuricemic: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred single-ingredient Antihyperuricemic? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No	Medications Taken (start and end date and dose):_____ _____ _____
Does the member have a history of contraindication to the prescribed medication?	☐ Yes ☐ No	

☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

KRYSTEXXA:

- ☐ If not prescribed by one of the following specialist rheumatologist or endocrinologist, please indicate a specialist consulted:_____
- ☐ Recent uric acid level above goal based on American College of Rheumatology guidelines:_____(submit labs)
- ☐ One of the following:
  - ☐ Continues to have frequent gout flares (≥ 2 flares/year)
  - ☐ Has non-resolving subcutaneous tophi
- ☐ Krystexxa will not be used concomitantly with oral urate-lowering agents

- ☐ Member was counseled regarding the following:
  - ☐ Appropriate dietary and lifestyle modifications
  - ☐ Discontinuation of other medications know to precipitate gout attacks

KRYSTEXXA RENEWAL REQUEST:

- ☐ Documentation of improvement in disease severity since initiating Krystexxa, as evidenced by:_____
- ☐ If not prescribed by one of the following specialist rheumatologist or endocrinologist, please indicate a specialist consulted:_____
- ☐ Does not have a history of a contraindication to Krystexxa
- ☐ Krystexxa will not be used concomitantly with oral urate-lowering agents

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)