UnitedHealthcare Community Plan

Antihyperuricemic Agents - Washington
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS:

- **Does the patient have a diagnosis of symptomatic hyperuricemia associated with gout confirmed by one of the following: □ Yes □ No**
  - □ Measurement of blood uric acid levels
  - □ Measurement of erythrocyte sedimentation rate
  - □ Polarized light microscopy for identification of crystal in synovial fluids obtained from joints or bursas (as well as material aspirated from tophaceous deposits, if any)
  - □ Magnetic resonance imaging for gouty tophus

- **Has the patient had one of the following: □ Yes □ No (check which applies)**
  - □ Greater than or equal to (≥) 3 gout flares in the previous 18 months that were inadequately controlled by colchicine, corticosteroids, or non-steroidal anti-inflammatory drugs (NSAIDs)
  - □ At least 1 gout tophus or gouty arthritis

- **Does the patient have a history of failure, contraindication, or intolerance to at least 3 months of allopurinol at maximum tolerated dose? □ Yes □ No**
  (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- **Have medications known to precipitate gout attacks been discontinued or changed when possible? □ Yes □ No**

Requests for ULORIC:

- **Does the patient have a history of cardiovascular disease (e.g. non-fatal myocardial infarctions (MI), and non-fatal strokes)? □ Yes □ No**

- **Does the patient meet one of the following: □ Yes □ No (check which applies)**
  - □ For symptomatic hyperuricemia associated with gout dose less than or equal to (≤) 80mg per day
  - □ For prophylaxis of increased uric acid level, in patients receiving chemotherapy and at intermediate to high risk of tumor lysis syndrome
    - □ Dose less than or equal to (≤) 120mg per day for 7 to 9 days, starting 2 days prior to chemotherapy
    - □ Dose less than or equal to (≤) 60mg per day for 6 to 14 days, starting 24 hours prior to chemotherapy

Requests for ZURAMPIC:

- **Is Zurampic being used in combination with a xanthine oxidase inhibitor (e.g. allopurinol, Uloric)? □ Yes □ No**

Requests for DUZALLO:

- **Does the patient have a history of severe renal impairment (CrCl <30ml/min)? □ Yes □ No**

Requests for KRYSTEXXA:

- **Does the patient have a history of failure, contraindication, or intolerance to at least 3 months of xanthine oxidase inhibitor (e.g. allopurinol, Uloric) at maximum tolerated dose? □ Yes □ No**
  (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- **Does the patient have a history of failure, contraindication, or intolerance to at least 3 months of Zurampic plus either allopurinol or Uloric; or Duzallo? □ Yes □ No**
  (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- **Have medications known to precipitate gout attacks been discontinued or changed when possible? □ Yes □ No**

- **Does the patient have a history of G6PD deficiency? □ Yes □ No**

Requests for CONTINUATION OF THERAPY:

- **Does the patient have a confirmed positive clinical response? □ Yes □ No**
  If yes, list response: _____

_____

Provider Signature: _____ **Date:** _____