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

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Last Name:</th>
<th>Member ID:</th>
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Address:

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<tr>
<th>City:</th>
<th>State:</th>
<th>ZIP Code:</th>
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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

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Last Name:</th>
<th>M.D./D.O.</th>
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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

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Strength</th>
<th>Directions</th>
<th>Dates of Therapy</th>
<th>Reason for failure / discontinuation</th>
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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.
# Antihyperuricemic Agents - Washington

## Prior Authorization Request Form

### 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: __________________________

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**Provider Signature:** __________________________

**Date:** __________________________

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