



# 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.covermyeds.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:
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### IV. REQUIRED DOCUMENTATION (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: \_\_\_\_\_

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

If requesting for daily quantity exceeding daily limit (Refer to <https://www.pahealthwellness.com/providers/pharmacy.html> under PHW Quantity Limit List), 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:
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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.)