

ZURAMPIC (lesinurad) PRIOR AUTHORIZATION FORM

- Please submit **all** requested documentation with this form. Incomplete documentation may delay the processing of this request.
- Prior authorization and quantity limits guidelines may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Antihyperuricemics** and **Quantity Limits/Daily Dose Limits** accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION INFORMATION			PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request:	Prescriber name:	
<input type="checkbox"/> Renewal request	PA# _____	_____		
Name of office contact:			Specialty:	
Contact's phone number:			State license #:	
LTC facility contact/phone:			NPI:	MA Provider ID#:
RECIPIENT INFORMATION			Street address:	
Recipient Name:			Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Medication requested: <input type="checkbox"/> Zurampic (non-preferred)	Strength: <input type="checkbox"/> 200 mg tablet <input type="checkbox"/> other: _____
Dose/directions:	Quantity: Refills:
Diagnosis:	Dx code (<i>required</i>):
1. Is the Recipient being treated for hyperuricemia associated with gout?	<input type="checkbox"/> Yes – <i>submit documentation.</i> <input type="checkbox"/> No – <i>submit medical literature supporting the use of Zurampic for the Recipient's diagnosis.</i>
2. Is the Recipient currently taking the maximal dose of a xanthine oxidase inhibitor for the treatment of chronic gout (ex., allopurinol, Uloric)?	<input type="checkbox"/> Yes <i>Submit documentation of name(s) and dose(s) of gout medications.</i> <input type="checkbox"/> No
3. Has the Recipient failed to achieve target uric acid levels despite treatment with the maximal dose of a xanthine oxidase inhibitor?	<input type="checkbox"/> Yes <i>Submit results of a recent uric acid level obtained while taking a xanthine oxidase inhibitor.</i> <input type="checkbox"/> No
4. Does the Recipient have severe liver impairment (Child Turcotte Pugh Class C)?	<input type="checkbox"/> Yes <i>Submit supporting documentation.</i> <input type="checkbox"/> No
5. Does the Recipient have any of the following renal conditions? <i>Check all that apply.</i> <input type="checkbox"/> creatinine clearance (CrCl) < 45 ml/min <input type="checkbox"/> history of kidney transplant <input type="checkbox"/> end-stage renal disease (ESRD) <input type="checkbox"/> receiving dialysis	<input type="checkbox"/> Yes <i>Submit documentation, including recent results of kidney function tests (i.e., SCr, CrCl, GFR).</i> <input type="checkbox"/> No
6. Does the Recipient have either of the following contraindications to Zurampic? <input type="checkbox"/> tumor lysis syndrome <input type="checkbox"/> Lesch-Nyhan syndrome	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
7. <i>If being treated for hyperuricemia associated with gout</i> , will the Recipient be taking Zurampic in addition to a xanthine oxidase inhibitor (ex., allopurinol, Uloric)?	<input type="checkbox"/> Yes <i>Submit documentation of medication regimen.</i> <input type="checkbox"/> No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
------------------------------	--------------

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.