

## ANTHYPERURICEMICS PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines for Antihyperuricemics, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Antihyperuricemics** (accessible at: <http://www.dhs.pa.gov/provider/pharmacy/services/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA#: _____)	Prescriber name:	
<input type="checkbox"/> Renewal request	# of pages in request: _____		
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

<b>Non-preferred medication requested:</b> <input type="checkbox"/> colchicine 0.6 mg capsule <input type="checkbox"/> Colcris tablet <input type="checkbox"/> Zylprim tablet <input type="checkbox"/> colchicine 0.6 mg tablet <input type="checkbox"/> Uloric tablet <input type="checkbox"/> _____ <span style="float: right;"><b>For Zurampic requests please use the Zurampic fax form.</b></span>			
Strength:	Directions:	Quantity:	Refills:
Diagnosis ( <i>submit documentation</i> ):		Dx code (required):	
Section A: Uloric requests			
1. Has the Recipient tried and failed, or has a contraindication or intolerance to, the preferred Antihyperuricemics? <i>Check all that apply.</i> <input type="checkbox"/> allopurinol tablet <input type="checkbox"/> probenecid tablet <input type="checkbox"/> probenecid/colchicine tablet		<input type="checkbox"/> Yes – <i>submit all supporting documentation of drug regimen and treatment outcome</i> <input type="checkbox"/> No	
Section B: All single-ingredient colchicine (Colcris, Mitigare, colchicine tablets, colchicine capsules) requests			
1. Does the Recipient have a history of any of the following? <i>Check all that apply.</i> <input type="checkbox"/> liver impairment <input type="checkbox"/> ascites <input type="checkbox"/> hepatitis <input type="checkbox"/> liver failure <input type="checkbox"/> cirrhosis <input type="checkbox"/> encephalopathy <input type="checkbox"/> renal/kidney impairment		<input type="checkbox"/> Yes – <i>submit recent kidney function test results (SCr, CrCl, GFR) and liver function test (LFT) results (bilirubin, albumin, and PT/INR)</i> <input type="checkbox"/> No	
2. Is the Recipient currently taking, or taken within the past 14 days, a medication that is an inhibitor of P-glycoprotein (P-gp) or a strong inhibitor of cytochrome P450 3A4 (CYP3A4) (ex., amiodarone, diltiazem, certain HIV medications, quinidine, Ranexa, verapamil)?		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit Recipient's current complete medication list</i>	
3. <i>If colchicine is being used for an off-label indication (i.e., indication other than gout or Familial Mediterranean Fever), submit documentation of medical literature supporting the use of colchicine for the Recipient's diagnosis.</i>			
Section C: Colchicine (Colcris, Mitigare, colchicine tablets, colchicine capsules) for ACUTE GOUT ATTACKS			
1. Has the Recipient tried and failed, or have a contraindication or intolerance to, the following standard therapies for the <u>CURRENT</u> gout attack? <i>Check all that apply.</i> <input type="checkbox"/> Intra-articular (joint injection) or oral corticosteroids (ex. Depo-Medrol, Kenalog, Aristospan, etc.) <input type="checkbox"/> NSAIDs (ex. ibuprofen, indomethacin, naproxen, piroxicam, etc.) or COX-2 inhibitor (ex. Celebrex)		<input type="checkbox"/> Yes – <i>submit all supporting documentation of drug regimen (drug name, strength, directions, and dates tried) and treatment outcome</i> <input type="checkbox"/> No	
Section D: Colchicine (Colcris, Mitigare, colchicine tablets, colchicine capsules) for CHRONIC GOUT PROPHYLAXIS			
1. Did the Recipient recently start taking a uric acid lowering medication for gout prophylaxis, such as allopurinol, probenecid, or Uloric?		<input type="checkbox"/> Yes – <i>submit documentation of uric acid lowering medication prescribed, including dose and start date</i> <input type="checkbox"/> No	
2. <i>For Recipients who have been taking a uric acid lowering medication for more than 6 months, submit documentation of the following:</i> <input type="checkbox"/> a recent uric acid level <input type="checkbox"/> uric acid lowering medication(s) currently using or previously tried (including name, strength, daily dosage, dates taken) <input type="checkbox"/> therapeutic outcomes of uric acid lowering medication(s)			

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

Prescriber Signature:	Date:
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