AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Lesinurad (Zurampic)

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for lesinurad (Zurampic). Requests for doses above the FDA approved dose will not be considered. Requests will be considered for patients when the following criteria are met:

1. Patient is 18 years of age or older; and
2. Patient has a diagnosis of hyperuricemia associated with gout; and
3. Patient has not achieved target serum uric acid levels or patient remains symptomatic with a maximally tolerated dose of a xanthine oxidase inhibitor (allopurinol or febuxostat) for at least three months; and
4. Patient has documentation of a previous trial and therapy failure with probenecid in combination with a xanthine oxidase inhibitor; and
5. Patient has an estimated creatinine clearance (eCrCl) > 45 mL/min; and
6. Documentation is provided lesinurad will be used in combination with a xanthine oxidase inhibitor.
   a. If taking allopurinol, dose should be ≥ 300 mg per day (or ≥ 200 mg per day in patients with an eCrCl < 60 mL/min); and
7. Patient does not have a contraindication to therapy including any of the following:
   a. Severe renal impairment (eCrCl <30 mL/min)
   b. End stage renal disease
   c. Kidney transplant recipient
   d. On dialysis
   e. Tumor lysis syndrome
   f. Lesch-Nyhan syndrome

If criteria for coverage are met, initial requests will be given for six months. Continuation of therapy will be considered when the following criteria are met:

1. Patient continues to take medication in combination with a xanthine oxidase inhibitor.
   a. If taking allopurinol, dose should be ≥ 300 mg per day (or ≥ 200 mg per day in patients with an eCrCl < 60 mL/min); and
2. Patient has an eCrCl > 45 mL/min; and
3. Patient does not have a contraindication to therapy including any of the following:
   a. Severe renal impairment (eCrCl <30 mL/min)
   b. End stage renal disease
   c. Kidney transplant recipient
   d. On dialysis
   e. Tumor lysis syndrome
   f. Lesch-Nyhan syndrome
4. Documentation of a positive clinical response to lesinurad.

The required trials may be overridden when documented evidence is provided that the use of the agent(s) would be medically contraindicated.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

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Non-Preferred

☐ Zurampic

Strength: Dosage instructions: Quantity: Days supply:

Diagnosis:

Initial Requests:

Target serum uric acid level:

Current Serum Uric Acid Level (attach lab results):

Does patient remain symptomatic while on a maximally tolerated dose of a xanthine oxidase inhibitor for at least three months?
☐ Yes ☐ No

Document trial of a xanthine oxidase inhibitor:

Drug name and dose: Trial dates:

Reason for failure:

Document trial of a probenecid in combination with a xanthine oxidase inhibitor:

Drug name and dose: Trial dates:

Reason for failure:

Estimated creatinine clearance (eCrCl): Date calculated:

Will lesinurad be used in combination with a xanthine oxidase inhibitor? If taking allopurinol, dose should be ≥ 300 mg per day (or ≥ 200 mg per day in patients with an eCrCl < 60 mL/min).

☐ Yes, provide drug name and dose: ☐ No

Does patient have a contraindication to therapy including any of the following:

Severe renal impairment (eCrCl < 30 mL/min):	☐ Yes	☐ No
End stage renal disease:	☐ Yes	☐ No
Kidney transplant recipient:	☐ Yes	☐ No
On dialysis:	☐ Yes	☐ No
Tumor lysis syndrome:	☐ Yes	☐ No
Lesch-Nyhan syndrome:	☐ Yes	☐ No

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Renewal requests:
Is lesinurad being used in combination with a xanthine oxidase inhibitor? If taking allopurinol, dose should be ≥ 300 mg per day (or ≥ 200 mg per day in patients with an eCrCl < 60 mL/min).

☐ Yes, provide drug name and dose: ☐ No

Estimated creatinine clearance (eCrCl): Date calculated:

Does patient have a contraindication to therapy including any of the following:

Severe renal impairment (eCrCl < 30 mL/min):	☐ Yes	☐ No
End stage renal disease:	☐ Yes	☐ No
Kidney transplant recipient:	☐ Yes	☐ No
On dialysis:	☐ Yes	☐ No
Tumor lysis syndrome:	☐ Yes	☐ No
Lesch-Nyhan syndrome:	☐ Yes	☐ No

Provide documentation of positive clinical response to lesinurad therapy:

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste, and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.