Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Antihyperuricemics

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Patient Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is the requested drug being used for a diagnosis that is indicated in the United States Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication?

☐ Yes ☐ No

Q2. Is the patient age appropriate for the requested drug according to Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q3. Is the prescribed dose and duration of therapy consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Does the patient have a history of contraindication to the prescribed medication?

☐ Yes ☐ No

Q5. Is this a request for a non-preferred antihyperuricemic?

☐ Yes ☐ No

Q6. Does the patient have a documented history of therapeutic failure, intolerance or contraindication to maximum tolerated doses of the preferred antihyperuricemics approved or medically accepted for the diagnosis?

☐ Yes ☐ No

Q7. Is this request for a single-ingredient oral colchicine agent?

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Patient Name:	Prescriber Name:

☐ Yes	☐ No
Q8. Will the requested drug be used for treatment of an acute gout attack?	
☐ Yes	☐ No
Q9. Will the requested drug be used for the treatment of chronic gout?	
☐ Yes	☐ No
Q10. Does the patient have a recent uric acid level that is above goal based on the American College of Rheumatology guidelines?	
☐ Yes	☐ No
Q11. Has the patient failed to achieve a positive clinical response (e.g., reduction in flare rate, resolution of tophi, decrease in pain and decreased functional impairment) using the maximum tolerated doses of standard uric acid lowering medication for the prophylaxis of gout attacks (such as xanthine oxidase inhibitors or probenecid)?	
☐ Yes	☐ No
Q12. Is the patient being prescribed colchicine in combination with a uric acid lowering medication recently started for the prophylaxis of gout attacks (such as allopurinol, probenecid or febuxostat)?	
☐ Yes	☐ No
Q13. Does the patient have a documented history of therapeutic failure, intolerance or contraindication to one of the following at doses and frequencies consistent with medically accepted standards for the treatment of gout: A) Nonsteroidal anti-inflammatory drug [NSAID] or cyclooxygenase-2 [COX-2] inhibitor or B) Intra-articular or systemic corticosteroids?	
☐ Yes	☐ No
Q14. Is the request for Krystexxa (pegloticase)?	
☐ Yes	☐ No
Q15. If this a request continuation of therapy with the requested agent (i.e. Has the requested drug been previously approved through prior authorization)?	
☐ Yes	☐ No
Q16. Is the requested drug prescribed by or in consultation with an appropriate specialist (i.e., rheumatologist, endocrinologist)?	
☐ Yes	☐ No
Q17. Does the patient have a recent uric acid level that is above goal based on American College of Rheumatology guidelines?	
☐ Yes	☐ No

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Q18. Will the requested drug be used concomitantly with oral urate-lowering agents?

☐ Yes ☐ No

Q19. Has the patient been counseled regarding both of the following: A) Appropriate dietary and life style modifications, and B) Discontinuation of other medications known to precipitate gout attacks (e.g., thiazide diuretics)? Note: Please attach documentation of this counseling.

☐ Yes ☐ No

Q20. Has the patient experienced improvement in disease severity since initiating treatment with Krystexxa (pegloticase)? Note: Please attach documentation.

☐ Yes ☐ No

Q21. Is the requested drug prescribed by or in consultation with an appropriate specialist (i.e., rheumatologist, endocrinologist)?

☐ Yes ☐ No

Q22. Will the requested drug be used concomitantly with oral urate-lowering agents?

☐ Yes ☐ No

Q23. Additional Information:

Prescriber Signature

Date

Updated for 2020