



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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.

Form with fields: Patient Name, Prescriber Name, HPP Member Number, Date of Birth, Patient Primary Phone, Address, City, State ZIP, Line of Business, Drug Name, Quantity, 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 xanthine oxidadse inhibitor that has a documented history of therapeutic failure, contraindication or intolerance to maximum tolerated doses of the preferred xanthine oxidase inhibitors?

Yes No

Q6. Is this a request for a non preferred single agent colchicine agent, that has a documented history of therapeutic failure, contraindication or intolerance to the preferred single-ingredient colchicine agents?

Yes No

Q7. Is this a request for any other non preferred antihyperuricemics, that has a documented history of therapeutic

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Patient Name: Prescriber Name:

failure, contraindication or intolerance to maximum tolerated doses of the preferred antihyperuricemics?
Q8. Is the request for Krystexxa (pegloticase)?
Q9. If this a request continuation of therapy with the requested agent (i.e. Has the requested drug been previously approved through prior authorization)?
Q10. Is the requested drug prescribed by or in consultation with an appropriate specialist (i.e., rheumatologist, endocrinologist)?
Q11. Does the patient have a recent uric acid level that is above goal based on American College of Rheumatology guidelines?
Q12. Does the patient continue to have frequent gout flares (≥ 2 flares/year) or have non-resolving subcutaneous tophi?
Q13. Will the requested drug be used concomitantly with oral urate-lowering agents?
Q14. 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)?
Q15. Has the patient experienced improvement in disease severity since initiating treatment with Krystexxa (pegloticase)?
Q16. Is the requested drug prescribed by or in consultation with an appropriate specialist (i.e., rheumatologist, endocrinologist)?
Q17. Will the requested drug be used concomitantly with oral urate-lowering agents?

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Patient Name:	Prescriber Name:
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Q18. Requested Duration: <input type="checkbox"/> 12 Months
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Q19. Additional Information:
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\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

*Updated for 2022*