

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

1. Requirements for Prior Authorization of Antihyperuricemics

A. Prescriptions That Require Prior Authorization

Prescriptions for non-preferred Antihyperuricemics must be prior authorized. See Preferred Drug List (PDL) for the list of preferred Antihyperuricemics at:

http://www.providersynergies.com/services/documents/PAM_PDL_20101115.pdf

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a non-preferred Antihyperuricemic, the determination of whether the requested prescription is medically necessary will take into account the following:

- A. Whether the recipient has a documented history of therapeutic failure, intolerance or contraindication of the preferred Antihyperuricemics

OR

- B. For Colcrys, whether the recipient:

- a. Is being treated for an acute gout attack

AND

- i. Is 17 years of age or older

AND

- ii. Does not have a contraindication to Colcrys

AND

- iii. Has a documented history of therapeutic failure, intolerance, or contraindication to the following at doses and frequencies consistent with medically accepted standards for the treatment of gout:

1. NSAIDS or COX-2 Inhibitors

OR

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

2. Intra-articular or systemic
corticosteroids

OR

b. Is being treated for chronic gout

AND

i. Is 17 years of age or older

AND

ii. Does not have severe renal and/or hepatic impairment OR the dose of Colcys has been adjusted accordingly

AND

iii. Does not have a contraindication to Colcrys

AND

iv. Is being prescribed Colcrys in combination with a uric acid lowering medication recently started for the prophylaxis of gout attacks (such as allopurinol, probenecid or Uloric)

OR

c. Has a diagnosis of Familial Mediterranean Fever (FMF)

AND

i. Is 4 years of age or older

AND

ii. Does not have severe renal and/or hepatic impairment OR the dose of Colcys has been adjusted accordingly

AND

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

iii. Does not have a contraindication to Colcrys

OR

C. If the request does not meet the clinical review guideline listed above, but in the professional judgment of the physician reviewer, the therapy is medically necessary to meet the medical needs of the recipient

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B above to assess the medical necessity of the request for a prescription for a non-preferred Antihyperuricemic. If the guidelines in Section B are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

D. References

1. Treatment of Acute Gout. UpToDate ONLINE. Updated June 17, 2010. Accessed December 3, 2010.
2. Prevention of Recurrent Gout. UpToDate ONLINE. Updated October 7, 2010. Accessed December 16, 2010