pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ANTIHYPERURICEMICS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Antihyperuricemics** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	total # of pgs: ________	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary Name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

* * * For **Zurampic** and **Duzallo** requests, please use the **Zurampic/Duzallo** fax form. * * *

Medication requested:
- ☐colchicine 0.6 mg capsule *(preferred, clinical PA req'd)*
- ☐colchicine 0.6 mg tablet *(preferred, clinical PA req'd)*
- ☐Colcrys tablet *(non-preferred)*
- ☐Krystexxa vial *(non-preferred)*
- ☐Mitigare capsule *(non-preferred)*
- ☐______________________
- ☐Uloric tablet *(non-preferred)*
- ☐Zyloprim tablet *(non-preferred)*
- ☐______________________

Strength:	Directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (required):	

ULORIC/ZYLOPRIM REQUESTS

Question	Response
1. Has the beneficiary tried and failed, or has a contraindication or intolerance to, the preferred Antihyperuricemics? *Check all that apply.* ☐allopurinol tablet ☐probenecid tablet ☐probenecid/colchicine tablet	☐Yes – *Submit all supporting documentation of drug regimen and treatment outcome.* ☐No

SINGLE-INGREDIENT COLCHICINE (COLCRYS, MITIGARE, COLCHICINE TABLETS, COLCHICINE CAPSULES) REQUESTS

Question	Response
2. Does the beneficiary have a history of any of the following? *Check all that apply.* ☐liver impairment or failure ☐ascites ☐hepatitis ☐renal/kidney impairment ☐cirrhosis ☐encephalopathy	☐Yes – *Submit results of recent kidney and liver function tests.* ☐No
3. Is the beneficiary 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)?	☐Yes ☐No *Submit beneficiary's current complete medication list.*
4. ***For NON-PREFERRED Colcrys or Mitigare:*** Does the beneficiary have a history of trial and failure of, or contraindication/intolerance to, the preferred agents, **colchicine capsule** & **colchicine tablet**?	☐Yes ☐No *Submit all supporting documentation.*
5. ***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 beneficiary's diagnosis.	

COLCHICINE (COLCRYS, MITIGARE, COLCHICINE TABLETS, COLCHICINE CAPSULES) FOR ACUTE GOUT ATTACKS

Question	Response
6. Did the beneficiary try and fail, or have a contraindication or intolerance to, the following standard therapies for the CURRENT gout attack? *Check all that apply.* ☐Intra-articular (joint injection) or oral corticosteroids (ex. Depo-Medrol, Kenalog, Aristospan, etc.) ☐NSAIDs (ex. ibuprofen, indomethacin, naproxen, piroxicam, etc.) or COX-2 inhibitor (ex. Celebrex)	☐Yes – *Submit all supporting documentation of drug regimen (drug name, strength, directions, and dates tried) and treatment outcome.* ☐No

COLCHICINE (COLCRYS, MITIGARE, COLCHICINE TABLETS, COLCHICINE CAPSULES) FOR CHRONIC GOUT PROPHYLAXIS

Question	Response
7. Did the beneficiary recently start taking a uric acid (UA)-lowering medication for gout prophylaxis, such as allopurinol, probenecid, or Uloric?	☐Yes – *Submit documentation of UA-lowering med. prescribed, including dose and start date.* ☐No
8. ***For a beneficiary who has been taking a uric acid lowering medication for more than 6 months***, submit documentation of the following: ☐a recent uric acid level ☐therapeutic outcomes of uric acid lowering medication(s) ☐uric acid lowering medication(s) currently using or previously tried (including name, strength, daily dosage, dates taken)	

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

Prescriber Signature:	Date:

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