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 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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failure, contraindication or intolerance to maximum tolerated doses of the preferred antihyperuricemics?

☐ Yes ☐ No

Q8. Is the request for Krystexxa (pegloticase)?

☐ Yes ☐ No

Q9. 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

Q10. Is the requested drug prescribed by or in consultation with an appropriate specialist (i.e., rheumatologist, endocrinologist)?

☐ Yes ☐ No

Q11. Does the patient have a recent uric acid level that is above goal based on American College of Rheumatology guidelines?

☐ Yes ☐ No

Q12. Does the patient continue to have frequent gout flares (≥ 2 flares/year) or have non-resolving subcutaneous tophi?

☐ Yes ☐ No

Q13. Will the requested drug be used concomitantly with oral urate-lowering agents?

☐ Yes ☐ No

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)? Note: Please attach documentation of this counseling.

☐ Yes ☐ No

Q15. Has the patient experienced improvement in disease severity since initiating treatment with Krystexxa (pegloticase)? Note: Please attach documentation.

☐ Yes ☐ No

Q16. Is the requested drug prescribed by or in consultation with an appropriate specialist (i.e., rheumatologist, endocrinologist)?

☐ Yes ☐ No

Q17. Will the requested drug be used concomitantly with oral urate-lowering agents?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q18. Requested Duration:

☐ 12 Months

Q19. Additional Information:

_____ _____

Prescriber Signature Date

Updated for 2023