https://providers.amerigroup.com

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Lesinurad (Zurampic)

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. Patient information	2. Physician information
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	4. Strength	5. Directions	6. Quantity per 30 days
	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: CHECK ALL BOXES THAT APPLY

Note: Any areas not filled out are considered not applicable to your patient and MAY AFFECT THE OUTCOME of this request.

Prior authorization is required for lesinurad (Zurampic). Requests for doses above the FDA approved dose will not be considered. Requests will be considered for patients when the following criteria are met:

1) Patient is 18 years of age or older; and
2) Patient has a diagnosis of hyperuricemia associated with gout; and
3) Patient has not achieved target serum uric acid levels or patient remains symptomatic with a maximally tolerated dose of a xanthine oxidase inhibitor (allopurinol or febuxostat) for at least 3 months; and
4) Patient has documentation of a previous trial and therapy failure with probenecid in combination with a xanthine oxidase inhibitor; and
5) Patient has an estimated creatinine clearance (eCrCl) > 45 mL/min; and
6) Documentation is provided lesinurad will be used in combination with a xanthine oxidase inhibitor.
   a. If taking allopurinol, dose should be ≥ 300 mg per day (or ≥ 200 mg per day in patients with an eCrCl < 60 mL/min); and
7) Patient does not have a contraindication to therapy including any of the following:
   a. Severe renal impairment (eCrCl <30 mL/min)
   b. End stage renal disease
   c. Kidney transplant recipient
   d. On dialysis
   e. Tumor lysis syndrome
   f. Lesch-Nyhan syndrome

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Patient name:_____ **Patient ID #:** _____

If criteria for coverage are met, initial requests will be given for 6 months. Continuation of therapy will be considered when the following criteria are met:

1) Patient continues to take medication in combination with a xanthine oxidase inhibitor.
   a. If taking allopurinol, dose should be ≥ 300 mg per day (or ≥ 200 mg per day in patients with an eCrCl < 60 mL/min); and
2) Patient has an eCrCl > 45 mL/min; and

a. Severe renal impairment (eCrCl <30 mL/min)
b. End stage renal disease
c. Kidney transplant recipient
d. On dialysis
e. Tumor lysis syndrome
f. Lesch-Nyhan syndrome

3) Patient does not have a contraindication to therapy including any of the following:
4) Documentation of a positive clinical response to lesinurad.

The required trials may be overridden when documented evidence is provided that the use of the agent(s) would be medically contraindicated.

Initial requests:

Target Serum Uric Acid Level:_____**Current**

Serum Uric Acid Level (attach lab results):_____

Does patient remain symptomatic while on a maximally tolerated dose of a xanthine oxidase inhibitor for at least 3 months? ☐ Yes ☐ No

Attach lab results and other documentation as necessary.

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Document trial of a xanthine oxidase inhibitor:

Drug name & dose:_____Trial dates: _____

Reason for failure: _____

Document trial of a probenecid in combination with a xanthine oxidase inhibitor:

Drug name & dose:_____Trial dates: _____

Reason for failure: _____

Document trial of a probenecid in combination with a xanthine oxidase inhibitor:

Drug name & dose:_____Trial dates: _____

Reason for failure:_____

Estimated Creatinine Clearance (eCrCl):_____Date calculated: _____

Will lesinurad be used in combination with a xanthine oxidase inhibitor? If taking allopurinol, dose should be ≥ 300 mg per day (or ≥ 200 mg per day in patients with an eCrCl < 60 mL/min).

☐ Yes, provide drug name and dose:_____ ☐ No

Does patient have a contraindication to therapy including any of the following:

Severe renal impairment (eCrCl < 30 mL/min):	☐ Yes	☐ No
End stage renal disease:	☐ Yes	☐ No
Kidney transplant recipient:	☐ Yes	☐ No
On dialysis:	☐ Yes	☐ No
Tumor lysis syndrome:	☐ Yes	☐ No
Lesch-Nyhan syndrome:	☐ Yes	☐ No

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Renewal requests:

Is lesinurad being used in combination with a xanthine oxidase inhibitor? If taking allopurinol, dose should be ≥ 300 mg per day (or ≥ 200 mg per day in patients with an eCrCl < 60 mL/min).

☐ Yes, provide drug name and dose_____ ☐ No

Estimated Creatinine Clearance (eCrCl):_____Date calculated: _____

Does patient have a contraindication to therapy including any of the following:

Severe renal impairment (eCrCl < 30 mL/min):	☐ Yes	☐ No
End stage renal disease:	☐ Yes	☐ No
Kidney transplant recipient:	☐ Yes	☐ No
On dialysis:	☐ Yes	☐ No
Tumor lysis syndrome:	☐ Yes	☐ No
Lesch-Nyhan syndrome:	☐ Yes	☐ No

Provide documentation of positive clinical response to lesinurad therapy: _____

_____

_____

Patient name:_____ **Patient ID #:** _____

9. Physician signature

_____ _____
Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.