

OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete forms will delay the authorization process.

Drug Requested: Zurampic® (lesinurad) (Non-Preferred) (MEDICAID)

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Form: _____ Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Quantity Limit: 1 per day Length of Authorization: 1 year

CLINICAL CRITERIA: The following criteria **MUST** be met to qualify or authorization process will be delayed.

- Patient has **NOT** achieved target serum uric acid levels (< 6 mg per dL; 355 µmol per L) with a xanthine oxidase inhibitor alone;
AND
- Patient must take in combination with a xanthine oxidase inhibitor;
AND
- Patient must be a minimum of 18 years of age

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

*REVISED/UPDATED: 7/1/2018