OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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)**

DRUG INFORMATON: 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 to ensure authorization will **NOT** 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:** ~~6/30/2017; 9/1/2017;~~ **9/1/2018**