OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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 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 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:** 6/30/2017; **9/1/2017**;