MOLINA HEALTHCARE

Iowa Department of Human Services

Iowa Health Link IOWA HHS Hawki Iowa HHS

Request for Prior Authorization

Lesinurad (Zurampic)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (877) 733-3195
Provider Help Desk
1 (844) 236-1464

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

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

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
3) 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
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.

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Non-Preferred

☐ Zurampic

Strength	Dosage Instructions	Quantity	Day's Supply

Diagnosis:_____

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

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:_____

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:_____

_____

_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*