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Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Anti-Gout Agents
Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist**.

Member information

Last name _____ First name _____ MI _____
MassHealth member ID # _____ Date of birth _____
Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Medication requested

☐ colchicine capsule
☐ colchicine tablet
☐ Duzallo (lesinurad/allopurinol)
☐ Krystexxa (pegloticase)
☐ Uloric (febuxostat)
☐ Zurampic (lesinurad)

Dose and frequency of medication requested _____

For colchicine tablet requests for treatment of acute gout, how many tablets will be used per acute attack? (Note: FDA-approved dosing is three colchicine tablets per acute attack.) _____

Indication for anti-gout agent requested (Check all that apply.)

☐ Treatment of gout
☐ Prophylaxis of gout
☐ Other _____ (Attach a letter regarding medical necessity.)

Please provide any serum urate level results and date obtained.

1. Lab value _____ Date obtained _____
2. Lab value _____ Date obtained _____
3. Lab value _____ Date obtained _____
4. Lab value _____ Date obtained _____

Section I. Please complete for treatment of gout attacks with colchicine tablets.*

1. Has the member used the FDA-approved dosing of up to three tablets per attack?
   ☐ Yes. If yes, please document the outcome of the trial.
   Outcome _____
   ☐ No. Please describe clinical rationale why the FDA-approved dosing has not been used.
   _____

2. Has the member tried a nonsteroidal anti-inflammatory drug (NSAID) and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please document drug name with dose and frequency, dates of use, and outcome.
   Drug _____ Dose and Frequency _____
   Dates/Duration _____ Outcome _____
   ☐ No. Please document if there is a contraindication to NSAID therapy.
   _____

3. Has the member tried a corticosteroid and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please document drug name with dose and frequency, dates of use, and outcome.
   Drug _____ Dose and Frequency _____
   Dates/Duration _____ Outcome _____
   ☐ No. Please document if there is a contraindication to corticosteroid therapy.
   _____

Section II. Please complete for prophylactic use of colchicine for gout with urate lowering therapy.*

1. Will the member be taking the requested medication concurrently with a new start of allopurinol, Uloric (febuxostat), or probenecid?
   ☐ Yes. Please document drug name with dose and frequency and dates of use.
   Drug _____ Dose and Frequency _____ Dates/Duration _____
   ☐ No. Please describe clinical rationale why concurrent therapy is not appropriate for this member.
   _____

2. What is the expected duration of colchicine therapy? **Please note:** requests for > six months will require additional clinical rationale for need of further treatment.
   _____

3. Does the member have tophaceous gout? ☐ Yes ☐ No

Section III. Please complete for prophylactic use of colchicine for gout without urate lowering therapy.*

1. Has the member tried allopurinol and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please document dose and frequency, dates of use, and outcome.
   Dose and Frequency _____ Dates/Duration _____
   Outcome _____
   ☐ No. Please document if there is a contraindication to allopurinol therapy.
   _____

2. Has the member tried Uloric (febuxostat) and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please document dose and frequency, dates of use, and outcome.
   Dose and Frequency _____ Dates/Duration _____
   Outcome _____
   ☐ No. Please document if there is a contraindication to Uloric (febuxostat) therapy.
   _____

Section IV. Please complete for treatment of gout with Duzallo (lesinurad/allopurinol) or Krystexxa (pegloticase).*

1. Has the member tried allopurinol and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please document dose and frequency, dates of use, and outcome.
   Dose and Frequency _____ Dates/Duration _____
   Outcome _____
   ☐ No. Please document if there is a contraindication to allopurinol therapy.
   _____

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2. Has the member tried Uloric (febuxostat) and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please document dose and frequency, dates of use, and outcome.
   Dose and Frequency _____ Dates/Duration _____
   Outcome _____
   ☐ No. Please document if there is a contraindication to Uloric (febuxostat) therapy.
   _____

3. Has the member tried a uricosuric agent in combination with allopurinol or Uloric (febuxostat) and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please document drug names with dose and frequency, dates of use, and outcome.
   Drug _____ Dose and Frequency _____
   Dates/Duration _____ Outcome _____
   Drug _____ Dose and Frequency _____
   Dates/Duration _____ Outcome _____
   ☐ No. Please document if there is a contraindication to uricosuric agent therapy.
   _____

4. For Krystexxa, has the member tried Zurampic (lesinurad) in combination with allopurinol or Uloric (febuxostat) and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please document drug names with dose and frequency, dates of use, and outcome.
   Drug _____ Dose and Frequency _____
   Dates/Duration _____ Outcome _____
   Drug _____ Dose and Frequency _____
   Dates/Duration _____ Outcome _____
   ☐ No. Please document if there is a contraindication to Zurampic (lesinurad) therapy.
   _____

Section V. Please complete for treatment of gout with Uloric (febuxostat).*

Has the member tried allopurinol and experienced an adverse reaction or inadequate response?
☐ Yes. Please document dose and frequency, dates of use, and outcome.
Dose and Frequency _____ Dates/Duration _____
Outcome _____
☐ No. Please document if there is a contraindication to allopurinol therapy.
_____

Section VI. Please complete for treatment of gout with Zurampic (lesinurad).*

1. Has the member tried allopurinol or Uloric (febuxostat) and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please document drug name with dose and frequency, dates of use, and outcome.
   Drug _____ Dose and Frequency _____
   Dates/Duration _____ Outcome _____
   ☐ No.
2. Has the member tried probenecid in combination with allopurinol or Uloric (febuxostat) and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please document drug names with dose and frequency, dates of use, and outcome.
   Drug _____ Dose and Frequency _____
   Dates/Duration _____ Outcome _____
   Drug _____ Dose and Frequency _____
   Dates/Duration _____ Outcome _____
   ☐ No. Please document if there is a contraindication to probenecid therapy.
   _____

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3. Will the member be taking the requested medication concurrently with allopurinol or Uloric (febuxostat)?
   ☐ Yes. Please document drug name with dose and frequency and dates of use.
   Drug _____ Dose and Frequency _____
   Dates/Duration _____
   ☐ No. Please explain. _____

Section V. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

_____

_____

**Attach a letter with additional information regarding medication trials as applicable.*

Prescriber information

Last name* _____ First name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

** Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____