



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

- | | |
|--|--|
| <input type="checkbox"/> colchicine capsule | <input type="checkbox"/> febuxostat |
| <input type="checkbox"/> colchicine tablet | <input type="checkbox"/> Krystexxa (pegloticase) |
| <input type="checkbox"/> Duzallo (lesinurad/allopurinol) | <input type="checkbox"/> 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 (Check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Treatment of gout | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Prophylaxis of gout | (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.*

- 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.

- 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, 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 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 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.

2. Has the member tried 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 febuxostat therapy.

3. Has the member tried a uricosuric agent in combination with allopurinol or 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 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 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 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 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.

3. Will the member be taking the requested medication concurrently with allopurinol or febuxostat?

Yes. Please document drug name with dose and frequency and dates of use.

Drug _____ Dose and Frequency _____

Dates/Duration _____

No. Please explain. _____

Section VII. 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 _____