



**MEDICAID / CHIP**  
**PHARMACY PRIOR AUTHORIZATION REQUEST FORM**

**Antihyperuricemics**

Phone: 866-841-7659

Fax back to: 866-240-3712

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.**

Member Name:		Prescriber Name:	
Member ID Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Phone Number:	NPI:	PA PROMISe ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..</i>			

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

***Please answer the following questions and sign.***

Q1. Is the requested drug being used for a diagnosis that is indicated in the United States Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication?

Yes

No

Q2. Is the patient age appropriate for the requested drug according to Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes

No

Q3. Is the prescribed dose and duration of therapy consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes

No

Q4. Does the patient have a history of contraindication to the prescribed medication?

Yes

No

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<p>Q5. Is this a request for a non preferred xanthine oxidase inhibitor that has a documented history of therapeutic failure, contraindication or intolerance to maximum tolerated doses of the preferred xanthine oxidase inhibitors?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q6. Is this a request for a non preferred single agent colchicine agent, that has a documented history of therapeutic failure, contraindication or intolerance to the preferred single-ingredient colchicine agents?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q7. Is this a request for any other non preferred antihyperuricemics, that has a documented history of therapeutic failure, contraindication or intolerance to maximum tolerated doses of the preferred antihyperuricemics?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q8. Is the request for Krystexxa (pegloticase)?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q9. If this a request continuation of therapy with the requested agent (i.e. Has the requested drug been previously approved through prior authorization)?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q10. Is the requested drug prescribed by or in consultation with an appropriate specialist (i.e., rheumatologist, endocrinologist)?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q11. Does the patient have a recent uric acid level that is above goal based on American College of Rheumatology guidelines?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q12. Does the patient continue to have frequent gout flares (<math>\geq 2</math> flares/year) or have non-resolving subcutaneous tophi?</p>



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<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q13. Will the requested drug be used concomitantly with oral urate-lowering agents?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q14. Has the patient been counseled regarding both of the following: A) Appropriate dietary and life style modifications, and B) Discontinuation of other medications known to precipitate gout attacks (e.g., thiazide diuretics)? Note: Please attach documentation of this counseling.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q15. Has the patient experienced improvement in disease severity since initiating treatment with Krystexxa (pegloticase)? Note: Please attach documentation.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q16. Is the requested drug prescribed by or in consultation with an appropriate specialist (i.e., rheumatologist, endocrinologist)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q17. Will the requested drug be used concomitantly with oral urate-lowering agents?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q18. Requested Duration:	
<input type="checkbox"/> 12 Months	
Q19. Additional Information:	

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

v2026-06