Updated: 08/2018
PARP Approved: 08/2018

Prior Authorization Criteria

Duzallo (lesinurad/allopurinol)

All requests for Duzallo (lesinurad/allopurinol) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Duzallo (lesinurad/allopurinol) Prior Authorization Criteria:
For all requests for Duzallo (lesinurad/allopurinol) all of the following criteria must be met:

Coverage may be provided with a diagnosis of hyperuricemia associated with gout in members who have not achieved target serum uric acid levels with a medically appropriate daily dose of allopurinol alone and the following criteria is met:

- Documentation the member has tried and failed (for at least 8 weeks) or had an intolerance or contraindication to a 300mg daily dose of allopurinol.

- **Initial Duration of Approval:** 12 months

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Gateway Health

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DUZALLO (LESINURAD/ALLOPURINOL) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health[SM] Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: ____________pounds or ____________kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:______________

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: ☐ Hyperuricemia associated with gout ☐ Other: ________________________

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date