Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: _______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: _____________________

Physician Fax#: _____________________ Pharmacy Name: ____________________________ Pharmacy Phone: __________________

Horizon NJ Health

Medical Necessity Request

*****Complete page 1 for Initial Requests Only*****

<u>Diagnosis Information</u> <u>(please indicate the diagnosis and answer the related questions):</u>

What is the member's diagnosis? □ Gout □ Other ____

Request for Febuxostat (Uloric)

1. Has the member tried allopurinol? **Yes** or **No**
   If no, can the member try allopurinol instead? **Yes** or **No**
   If yes, please call the pharmacy, then return form to HNJH
   If no, please provide clinical reason why not? ____
   If yes, did the member experience an inadequate treatment response to allopurinol (failure to achieve uric acid levels <6mg/dL) after optimal therapy? **Yes** or **No**
   If no, what was the response to allopurinol?
   ____
2. Does the member have established cardiovascular disease (CVD)? **Yes** or **No**

Request for Lesinurad (Zurampic)

1. Has the member tried allopurinol or febuxostat? **Yes** or **No**
   If no, can the member try allopurinol or febuxostat instead? **Yes** or **No**
   If yes, please call the pharmacy, then return form to HNJH
   If no, please provide clinical reason why not? ____
   If yes, did the member achieve target serum uric acid levels while on optimal therapy with allopurinol or febuxostat? **Yes** or **No**
   If no, what was the response to allopurinol or febuxostat? ____
2. Will the member be receiving xanthine oxidase inhibitor (e.g allopurinol, febuxostat) with Zurampic? **Yes** or **No**

Request for Pegloticase (Krystexxa)

1. Has the member tried allopurinol? **Yes** or **No**
   If no, can the member try allopurinol instead? **Yes** or **No**
   If yes, please call the pharmacy, then return form to HNJH
   If no, please provide clinical reason why not? ____
   If yes, did the member achieve target serum uric acid levels with allopurinol monotherapy? **Yes** or **No**
   If no, what was the response to the allopurinol? ____
2. Has the member tried allopurinol with probenecid? **Yes** or **No**
   If no, can the member try allopurinol with probenecid instead? **Yes** or **No**
   If yes, please call the pharmacy, then return form to HNJH
   If no, please provide clinical reason why not? ____
   If yes, has the member achieved target serum uric acid levels with allopurinol in combination with probenecid after optimal therapy? **Yes** or **No**
   If no, what was the response to the allopurinol in combination with probenecid? ______________________________
3. Will the member be using oral uric acid-lowering therapies with Krystexxa? **Yes** or **No**

Physician office's signature*__________________________________ Print Name________________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: _____________________

Physician Fax#: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

Horizon NJ Health

Medical Necessity Request

*****Complete page 2 only for Subsequent/Renewal requests*****

1. What is the member's diagnosis? □ Gout □ Other ____

2. Does the member have a documented positive clinical response to therapy? **Yes** or **No**

Physician office's signature*__________________________________ Print Name________________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**