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****

Diagnosis Information (please indicate the diagnosis and answer the related questions):

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 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**

Horizon NJ Health
Medical Necessity Request
****Complete page 2 only for Subsequent/Renewal requests****

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: _____

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**