BlueCross BlueShield of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

PHARMACY COVERAGE GUIDELINES	**ORIGINAL EFFECTIVE DATE: 9/15/16**
SECTION: DRUGS	**LAST REVIEW DATE: 9/20/18**
	LAST CRITERIA REVISION DATE: 9/20/18
	ARCHIVE DATE:

DUZALLO™ ((lesinurad and allopurinol) oral tablet
ZURAMPIC® (lesinurad) oral tablet

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. All other trademarks and service marks contained in this guideline are the property of their respective owners, which are not affiliated with BCBSAZ.

This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. All requested data must be provided. Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

DUZALLO™ ((lesinurad and allopurinol) oral tablet
ZURAMPIC® (lesinurad) oral tablet (cont.)

Criteria:

- **Criteria for initial therapy:** Duzallo (lesinurad/allopurinol) and Zurampic (lesinurad) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

1. Individual must be 18 years of age or older
2. A confirmed diagnosis of symptomatic hyperuricemia associated with gout
3. Serum uric acid level is ≥ 6.5 mg/dL on at least 3 months of xanthine oxidase inhibitor alone
4. **For Zurampic, ALL of the following:**
   - Individual has failure, contraindication or intolerance to maximally tolerated and renal adjusted doses of **2 oral xanthine oxidase inhibitors:**
     - Allopurinol
     - Uloric (febuxostat)
   - A xanthine oxidase inhibitor must be used simultaneously with Zurampic
   - Will not be used with Duzallo
5. **For Duzallo, ALL of the following:**
   - Individual has failure, contraindication or intolerance to renal adjusted doses of allopurinol (200 mg or 300 mg)
   - Individual has medical record documentation of being unable to adhere with use of renal adjusted doses of allopurinol (200 mg or 300 mg) **AND** Zurampic used at the same time
   - Will not be used with Zurampic
6. **ALL** of the following baseline tests have been completed before initiation of treatment with continued monitoring as clinically appropriate:
   - Comprehensive metabolic panel
   - Estimated creatinine clearance is ≥ 45 mL/min
7. Does not have severe hepatic impairment (Child-Pugh Class C)
8. There are **NO** contraindications
   - Contraindications include:
     - Severe renal impairment (eCrCl < 30 mL/min)
     - End stage renal disease (ESRD)
     - Dialysis patients
     - Kidney transplant recipients
     - Tumor lysis syndrome
     - Lesch-Nyhan syndrome

Initial approval duration: 6 months

DUZALLO™ ((lesinurad and allopurinol) oral tablet
ZURAMPIC® (lesinurad) oral tablet (cont.)

- **Criteria for continuation of coverage (renewal request):** Duzallo (lesinurad/allopurinol) and Zurampic (lesinurad) is considered ***medically necessary*** and will be approved with documentation of **ALL** of the following:

1. Individual's condition responded while on therapy
    - Response is defined as:
        - Achieved and maintains uric acid levels < 6.5 mg/dL
        - Achieved and maintains a reduction in gout flares

2. Individual has been adherent with the medication

3. Individual has not developed any contraindications or other significant level 4 adverse drug effects that may exclude continued use, such as:
    - Contraindications as listed in the criteria for initial therapy section listed above
    - Significant adverse effect such as:
        - Uric acid nephropathy
        - Kidney dysfunction
        - Allopurinol induced rash/severe hypersensitivity
        - Allopurinol induced hepatotoxicity
        - Allopurinol induced bone marrow suppression

4. Estimated creatinine clearance is ≥ 45 mL/min

5. Zurampic: continues to be used with a xanthine oxidase inhibitor

6. There are no significant interacting drugs

Renewal duration: 12 months

Description:

Zurampic (lesinurad) is **indicated in combination with a xanthine oxidase inhibitor for the treatment of hyperuricemia associated with gout who have not achieved target serum uric acid levels with a xanthine oxidase inhibitor alone**. Zurampic (lesinurad) is not recommended for the treatment of asymptomatic hyperuricemia and it should not be used as monotherapy. Duzallo (lesinurad and allopurinol) **inhibitor for the treatment of hyperuricemia associated with gout who have not achieved target serum uric acid levels with allopurinol (a xanthine oxidase inhibitor) alone.** Duzallo (lesinurad and allopurinol) is not recommended for the treatment of asymptomatic hyperuricemia.

Failure to take lesinurad with a xanthine oxidase inhibitor may increase the risk of renal adverse events. Xanthine oxidase inhibitors include allopurinol and Uloric (febuxostat).

DUZALLO™ ((lesinurad and allopurinol) oral tablet
ZURAMPIC® (lesinurad) oral tablet (cont.)

Llesinurad is a urate transporter 1 (URAT1) inhibitor that reduces serum uric acid concentrations by inhibiting the function of 2 transporter proteins involved in uric acid reabsorption in the kidney: uric acid transporter 1 (URAT1) and organic anion transporter 4 (OAT4). Lesinurad inhibited the function of two apical transporters responsible for uric acid reabsorption, uric acid transporter 1 (URAT1) and organic anion transporter 4 (OAT4). URAT1 is responsible for the majority of the reabsorption of filtered uric acid from the renal tubular lumen. OAT4 is a uric acid transporter associated with diuretic-induced hyperuricemia. Lesinurad does not interact with the uric acid reabsorption transporter SLC2A9 (Glut9), located on the basolateral membrane of the proximal tubule cell.

Allopurinol reduces the production of uric acid by inhibiting the biochemical reactions involved in uric acid formulation. Allopurinol is an inhibitor of xanthine oxidase, the enzyme that is responsible for conversion of hypoxanthine to xanthine and of xanthine to uric acid. Allopurinol is metabolized to oxypurinol which is also a xanthine oxidase inhibitor.

Definitions:

Allopurinol dose adjustments for kidney dysfunction

Creatinine Clearance (mL/min)	Daily Dose
> 20	300 up to max of 800 mg
10-20	200 mg
< 10	100 mg

Alternative Dosage Adjustment†	
Creatinine Clearance (mL/min)	Dose(milligrams) / Interval
140	400 mg/day, up to max dose 800 mg/day
120	350 mg/day
100	300 mg/day
80	250 mg/day
60	200 mg/day
40	150 mg/day
20	100 mg/day
10	100 mg/every 2 days
0	100 mg/every 3 days
† Micromedex: Allopurinol dose adjustment	

Resources:

Zurampic. Package Insert. Revised by manufacturer 01/2016. Accessed 09-12-2016, 08-28-2017, 07-19-2018.

DUZALLO™ ((lesinurad and allopurinol) oral tablet
ZURAMPIC® (lesinurad) oral tablet (cont.)

Micromedex® 2.0, (Allopurinol accessed electronic version). Truven Health Analytics, Greenwood Village, Colorado, USA. Available at: http://www.micromedexsolutions.com/ (cited: September 14, 2016).

UpToDate: Prevention of recurrent gout: Pharmacologic urate-lowering therapy and treatment of tophi. Current through Aug 2017. https://www-uptodate-com.mwu.idm.oclc.org/contents/prevention-of-recurrent-gout-pharmacologic-urate-lowering-therapy-and-treatment-of-tophi?source=search_result&search=Uric%20acid%20transporter%201%20(URAT1)%20inhibitor&selectedTitle=4~150

UpToDate: Pharmacologic urate-lowering therapy and treatment of tophi in patients with gout. Current through Jul 2018. https://www-uptodate-com.mwu.idm.oclc.org/contents/pharmacologic-urate-lowering-therapy-and-treatment-of-tophi-in-patients-with-gout

UpToDate: Treatment of gout flares. Current through Jul 2018. https://www-uptodate-com.mwu.idm.oclc.org/contents/treatment-of-gout-flares?search=gout&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

Fax completed prior authorization request form to 602-864-3126 or email to pharmacyprecert@azblue.com.
Call 866-325-1794 to check the status of a request.
All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned.**
Pharmacy Coverage Guidelines are available at www.azblue.com/pharmacy.

Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.
REQUIRED: Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Member Information

Member Name (first & last):	Date of Birth:	Gender:	BCBSAZ ID#:
Address:	City:	State:	Zip Code:

Prescribing Provider Information

Provider Name (first & last):	Specialty:	NPI#:	DEA#:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:	Office Fax:	

Dispensing Pharmacy Information

Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information

Medication Name:	Strength:		Dosage Form:
Directions for Use:	Quantity:	Refills:	Duration of Therapy/Use:

☐ Check if requesting **brand** only ☐ Check if requesting **generic**

☐ Check if requesting continuation of therapy (prior authorization approved by BCBSAZ expired)

Turn-Around Time For Review

☐ Standard ☐ Urgent. Sign here: _____ ☐ Exigent (requires prescriber to include a written statement)

Clinical Information

1. **What is the diagnosis? Please specify below.**

   ICD-10 Code: _____ **Diagnosis Description:** _____

2. ☐ Yes ☐ No **Was this medication started on a recent hospital discharge or emergency room visit?**

3. ☐ Yes ☐ No **There is absence of ALL contraindications.**

4. **What medication(s) has the individual tried and failed for this diagnosis? Please specify below.**
Important note: Samples provided by the provider are not accepted as continuation of therapy or as an adequate trial and failure.

Medication Name, Strength, Frequency	Dates started and stopped or Approximate Duration	Describe response, reason for failure, or allergy

5. **Are there any supporting labs or test results? Please specify below.**

Date	Test	Value

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

Pharmacy Prior Authorization Request Form

6. Is there any additional information the prescribing provider feels is important to this review? Please specify below.
For example, explain the negative impact on medical condition, safety issue, reason formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.

Signature affirms that information given on this form is true and accurate and reflects office notes

Prescribing Provider's Signature: Date:

Please note: Some medications may require completion of a drug-specific request form.

Incomplete forms or forms without the chart notes will be returned.

Office notes, labs, and medical testing relevant to the request that show medical justification are required.