



Request for Prior Authorization
FEBUXOSTAT (ULORIC®)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Prior authorization is required for febuxostat (Uloric®). Payment for febuxostat (Uloric®) will only be considered for cases in which symptoms of gout still persist while currently using 300mg per day of a preferred allopurinol product unless documentation is provided that such a trial would be medically contraindicated.

Non-Preferred

Febuxostat Uloric

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

Treatment failure with allopurinol:

Trial Drug Name: Trial Drug Strength:

Trial start date: Trial end date:

Reason for failure:

Possible drug interactions/conflicting drug therapies:

Attach lab results and other documentation as necessary.

Prescriber Signature: Date of Submission:

*MUST MATCH PRESCRIBER LISTED ABOVE

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid.