







FAX Completed Form To 1.833.404.2392

Pharmacy Help Desk 1.800.460.8988

Prescriber Help Desk 1.833.587.2012

Request for Prior Authorization FEBUXOSTAT (ULORIC®)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name		DOB
Patient address			
Provider NPI	Prescriber name		Phone
Prescriber address			Fax
Pharmacy name	Address		Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI	Pharmacy fax	NDC 	
Prior authorization is required for febuxostat (<i>Uloric</i> ®). Payment for febuxostat (<i>Uloric</i> ®) 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 Ulorio	;		
Strength	Dosage Instructions	Quantity	Days Supply
Diagnosis:			
Treatment failure with allopurinol:			
Trial Drug Name:	Trial Drug Strength:		
Trial start 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. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.