**Provider Help Desk** 1 (877) 776 –1567

FAX Completed Form To 1 (800) 574-2515

## Iowa Department of Human Services REQUEST FOR PRIOR AUTHORIZATION FEBUXOSTAT (ULORIC®)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid  Member ID #:	DOB:
Patient Address:	
Provider NPI:                   Prescriber Name:	Phone:
Prescriber Address:	Fax:
Pharmacy Name: Address: Prescriber must fill all information above. It must be legible, c	Phone: orrect and complete or form will be returned.
Pharmacy	
NPI:	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	
Uloric®	
Strength Dosage Instructions	Quantity Days Supply
	<del></del>
Diagnosis:	
Treatment failure with allopurinol:	
Trial Drug Name: Trial Drug	g Strength:
Trial start date: Trial end date:	Reason for failure:
Possible drug interactions/conflicting drug therapies:	
Attach lab results and other documentation as necessary.	
•	Data of Submissions
Prescriber Signature: **MUST MATCH PRESCRIBER LISTED ABOVE	Date of Submission:

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.