

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

ULORIC (febuxostat)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES AND THIS COMPLETED
FORM TO 855-828-4992 note the new fax number**

CRITERIA:

- Minimum age requirement: 18 years old.
- Documented diagnosis of Gout.
- Documented failure, contraindication, or intolerance to allopurinol.
- No concomitant use of azathioprine, mercaptopurine, or theophylline.

AUTHORIZATION:

The initial prior authorization will be approved for one year.

RE-AUTHORIZATION:

Updated letter of medical necessity

8/26/10

<http://health.utah.gov/medicaid/pharmacy>