Prescriber Criteria Form

Uloric 2025 PA Fax 2885-A v1 010125.docx
Uloric (febuxostat)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Uloric (febuxostat).

Drug Name:
Uloric (febuxostat)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.

1	Is the requested drug being prescribed for the chronic management of hyperuricemia in a patient with gout? [If no, then no further questions.]	Yes	No
2	Has the patient experienced an inadequate response to a maximally titrated dose of allopurinol? [If yes, then no further questions.]	Yes	No
3	Has the patient experienced an intolerance to allopurinol or is treatment with allopurinol not advisable for the patient?	Yes	No

Comments: ______________________________

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: ______________________________ **Date:**____________________