Uloric® (febuxostat)
Prior Authorization Form

ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

Complete Patient and Physician information (PLEASE PRINT)

STEP 1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:
	Tax ID or NPI Number:

If Applicable: Pharmacy Name: ______________________________
Pharmacy Phone: ______________________________

Complete the Clinical Assessment:

STEP 2

Diagnosis	☐ Chronic hyperuricemia, symptomatic gout	☐ Other (please state): ______________________ ______________________
Clinical Consideration	☐ Patient has been previously treated with allopurinol ☐ Patient has documented intolerance to allopurinol **-or-** ☐ Patient did not achieve adequate sUA lowering on allopurinol (<6mg/dL) (attach notes)	
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description / J Code (required):	
	Please include any chart notes related to allopurinol use and intolerance	
	Please attach all relevant medical records and test results. **Incomplete forms will not be processed.**	

STEP 3

I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

______________________________ ______________________
Prescriber Signature Date

STEP 4

Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:

970-248-5034

Name of Person filling out form: ______________________________

Pharmacy Technician initials Date Initiated

Confidentiality Notice:

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