Prior Authorization Request Form for
febuxostat (Uloric)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1

Please complete patient and physician information (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2

Please complete the clinical assessment:

1. Has the patient had a trial of allopurinol at a dose of at least 300 mg per day?	☐ Yes Proceed to question 2	☐ No Proceed to Question 3
2. Did the patient fail to achieve serum uric acid levels less than 6 mg/dL when using allopurinol 300 mg per day?	☐ Yes Proceed to question 5	☐ No Proceed to Question 3
3. Did the patient have an intolerable adverse effect to allopurinol (for example, hypersensitivity)?	☐ Yes Proceed to question 5	☐ No Proceed to Question 4
4. Does the patient have a contraindication to allopurinol (for example, renal impairment)?	☐ Yes Proceed to question 5	☐ No Stop Coverage not approved
5. Does the patient have major cardiovascular (CV) disease?	☐ Yes Proceed to question 6	☐ No Proceed to Question 6
6. Has the patient been informed of the potential CV risks when using this drug?	☐ Yes Proceed to question 7	☐ No Stop Coverage not approved
7. Has the health care provider considered CV safety information from the CARES trial and the label when prescribing febuxostat?	☐ Yes Sign and date below	☐ No Stop Coverage not approved

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Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[6 March 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: