

# Uloric (febuxostat)



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## Prior Authorization Request (Physician to Complete)

Visit [www.wellmark.com](http://www.wellmark.com) for the Wellmark Drug List for current medication tier levels and updated PA Forms

<b>Facsimile Transmittal Sheet</b>	Date: ____/____/____
To: <u>Wellmark Pharmacy Services</u>	From (Prescriber's Name): _____
Fax Number: <u>(866) 884-4345</u>	Prescriber's DEA Number: _____
Phone Number: <u>(800) 600-8065</u>	Prescriber's Phone Number: _____
Prescriber's Specialty: _____	Prescriber's Fax Number: _____
Prescriber's Office Address: _____	
Street	Suite # City State Zip
<b>Patient Name:</b> _____	
<b>Patient ID:</b> _____	<b>Patient DOB:</b> ____/____/____

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

### For Therapy Requests:

1. Please provide the diagnosis this therapy has been prescribed for: \_\_\_\_\_  
ICD-9 Code: \_\_\_\_\_
2. Is the drug being prescribed for the chronic management of hyperuricemia in a patient with gout?  Yes  No
3. Is the patient currently having an acute gout attack/flare?  Yes  No  
If yes, list the medications used to treat this current attack (i.e., colchicine, NSAIDS, et): \_\_\_\_\_
4. Has the patient had documented allopurinol hypersensitivity syndrome characterized by rash (e.g. toxic epidermal necrolysis and/or exfoliative dermatitis), eosinophilia, leukocytosis, fever, hepatitis and progressive renal disease?  Yes  No
5. Has the patient been unable to achieve serum uric acid levels  $\leq 6$  mg/dl with allopurinol to a maximum tolerable dose of up to 600-800 mg/day (or at least 300 mg/day for patients with renal insufficiency)?  Yes  No  
If yes, please describe: \_\_\_\_\_
6. Uloric Drug Strength: \_\_\_\_\_ mg      Quantity per Day: \_\_\_\_\_ unit

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

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