US Family Health Plan
Prior Authorization Request Form
for **febuxostat (Uloric)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

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:

Question	Yes	No
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

Step 3

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

____________________ __________

Prescriber Signature Date

[6 March 2019]