Prior Authorization Form

CAREFIRST - DC EXCHANGE 5T

Uloric Step Therapy (HMF)

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 **1-888-836-0730**.
Please contact CVS/Caremark at **1-855-582-2022** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Uloric Step Therapy (HMF).

Drug Name (select from list of drugs shown)
Febuxostat

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Is the requested drug being prescribed for the chronic management of hyperuricemia in an adult patient with gout?	Y N
	[If Yes, then go to 2. If No, then no further questions.]	
2.	Is this request for continuation of therapy?	Y N
	[If Yes, then go to 3. If No, then go to 4.]	
3.	Has the patient achieved or maintained a positive clinical response since beginning treatment with the requested drug?	Y N
	[No further questions.]	

4.	Has the patient experienced an inadequate treatment response to a maximally titrated dose of allopurinol?	Y N
	[If Yes, then no further questions. If No, then go to 5.]	
5.	Has the patient experienced an intolerance to allopurinol?	Y N
	[If Yes, then no further questions. If No, then go to 6.]	
6.	Is treatment with allopurinol contraindicated or inadvisable for the patient?	Y N
	[No further questions.]	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date