OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

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Uloric® (febuxostat) Prior Authorization Request Form DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

Member Information (required)			Р	Provider Information (required)			
Member Na	ame:		Provider Nam	Provider Name:			
Insurance ID#:			NPI#:	Specialty:			
Date of Birt	th:		Office Phone:	Office Phone:			
Street Address:			Office Fax:	Office Fax:			
City:	State:	ZIP:	Office Street	Office Street Address:			
Phone:			City:	State: ZII):	
		Medication	n Information	(required)			
Medication Name:			Strength:	Dosage F			
			Directions for	Directions for Use:			
		المناه المناه					
			nformation (re	quired)			
	ne patient have a diagnos					☐ Yes ☐ No	
2. Has the allopuri		inadequate treatmen	t response, intoleran	nse, intolerance or has a contraindication to		☐ Yes ☐ No	
						•	
Information	on this form is accurate	as of this date.					
Prescribe	er's Signature:			Date:			
Are there any this review?	other comments, diagnoses	s, symptoms, medication	s tried or failed, and/or	any other informatio	n the physician fe	els is important to	
Please note:	This request may be denie For more information about Monday – Friday: 8 a.m. to	the prior authorization pro	cess, please contact us a				

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