

## ULORIC PRIOR AUTHORIZATION REQUEST

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date:			
<b>SECTION A - PATIENT INFORMATION</b>			
First Name:		Last Name:	
Member ID:			
Address:			
City:		State:	Zip:
Phone:		DOB:	Allergies:
Primary Insurance:		Policy #:	Group #:
Is the requested medication <b>NEW</b> <input type="checkbox"/> or a <b>CONTINUATION of THERAPY</b> <input type="checkbox"/> ? If so, start date: _____			
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>SECTION B - PHYSICIAN INFORMATION</b>			
First Name:		Last Name:	
Address:		City:	State:      Zip:
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax Attention to:			
<b>SECTION C - MEDICAL INFORMATION</b>			
Medication:			Strength:
Directions for use:			
Diagnosis:		ICD-10 CODE:	Frequency of Administration:
How long has the patient been receiving the requested medication? List the time period _____			
Is this medication being prescribed to treat hyperuricemia in a patient with gout? Yes___ No___			
Has the patient tried and failed therapy with allopurinol? Yes___ No___			
Does this include an 8 week trial of allopurinol titrated to at least 600mg/daily? Yes___ No___			
Did the patient exhibit an inadequate response to treatment with allopurinol as evidenced by serum uric acid level >6mg/dL while on allopurinol therapy? Yes___ No___			
Did the patient experience an intolerance/adverse reaction to previous therapy with allopurinol? Yes___ No___			
Does the patient have a continuing contraindication to the use of allopurinol? Yes___ No___			
List contraindication/side effects _____			
Is the patient unable to receive a therapeutic dose of allopurinol due to renal impairment? Yes___ No___			

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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