UnitedHealthcare Community Plan

ULORIC
PRIOR AUTHORIZATION REQUEST

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

Today's Date:		
SECTION A - PATIENT INFORMATION		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:
Is the requested medication NEW □ or a CONTINUATION of THERAPY□? If so, start date:_____ **Is this patient currently hospitalized? □Yes □No**		

SECTION B - PHYSICIAN INFORMATION				
First Name:		Last Name:		
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

SECTION C - MEDICAL INFORMATION		
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: _____