

**PRIOR AUTHORIZATION REQUEST FORM**

**EOC ID:**



**EIC Uloric Step Therapy Exception Request Form**

**Phone: 866-250-2005 Fax back to: 877-503-7231**

ENVISION RX OPTIONS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State, Zip:	City, State, Zip:	
Member Phone:		

Drug Name: Expedited/Urgent

Directions:

<b>Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:</b>
Q1. Please indicate the patient's diagnosis below:
Q2. Is this initial or continuing therapy? Initial Therapy      Continuing Therapy
Q3. What is the anticipated duration of therapy?
Q4. Has the patient tried and failed the Step 1 medication Allopurinol? Yes      No
Q5. Please indicate the date allopurinol was tried.
Q6. If allopurinol has not been tried/failed, please indicate the reason it can not be used.
Q7. Please provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support a formulary exception request)
Q8. For medical necessity reviews, you must provide a unique peer-reviewed journal article to support your request for off-label use. Please attach any medical information that may support approval

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Date**