Pharmacy Medical Necessity Guidelines:
Febuxostat

Effective: April 14, 2026

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	Rx	Department to Review	RXUM
These pharmacy medical necessity guidelines apply to the following: ☒ Tufts Health RITogether – A Rhode Island Medicaid Plan		**Fax Numbers:** RXUM: 617.673.0939	

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

Febuxostat is a xanthine oxidase inhibitor indicated for chronic management of hyperuricemia in adult patients with gout who have an inadequate response to a maximally titrated dose of allopurinol, who are intolerant to allopurinol, or for whom treatment with allopurinol is not advisable. Febuxostat is not recommended for the treatment of asymptomatic hyperuricemia.

COVERAGE GUIDELINES

Note: Prescriptions that meet the initial step therapy requirements, will adjudicate at the point of service. If the member does not meet the initial step therapy criteria, then the prescription will deny at the point of service with a message indicating that prior authorization (PA) is required. Refer to the Coverage Criteria below and submit prior authorization requests to the plan using the Universal Pharmacy Medical Review Request Form for members who do not meet the step therapy criteria at the point of service.

Drug	Tufts Health RITogether
Step-1	
allopurinol	Covered
Step-2	
febuxostat	Requires prior use of allopurinol

Febuxostat

1. The Member has had an inadequate response or adverse reaction to a trial of allopurinol

OR

2. The Member has documented contraindication or intolerance to allopurinol

LIMITATIONS

1. Requests for brand-name products, which have AB-rated generics, will be reviewed according to non-covered medications criteria.

CODES

None

REFERENCES

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APPROVAL HISTORY

September 13, 2022: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. July 11, 2023: No changes.
2. April 9, 2024: Effective May 1, 2024, updated RxUM fax number.
3. April 8, 2025: No changes
4. April 14, 2026: No changes.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

Provider Services