



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Febuxostat

Page: 1 of 2

Effective Date: 5/23/2025

Last Review Date: 5/2025

Applies to:	<input type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input type="checkbox"/> Michigan
	<input checked="" type="checkbox"/> New Jersey	<input checked="" type="checkbox"/> Maryland	<input checked="" type="checkbox"/> Florida Kids
	<input checked="" type="checkbox"/> Pennsylvania Kids	<input checked="" type="checkbox"/> Virginia	<input type="checkbox"/> Kentucky PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for febuxostat under the patient's prescription drug benefit.

Description:

FDA-approved Indications

Febuxostat is a xanthine oxidase (XO) inhibitor indicated for the 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.

For the safe and effective use of allopurinol, see allopurinol prescribing information.

Limitations of Use

Febuxostat is not recommended for the treatment of asymptomatic hyperuricemia.

Drug List:

Febuxostat

Policy/Guideline:

Coverage Criteria

Hyperuricemia

Authorization may be granted when the requested drug is being prescribed for the chronic management of hyperuricemia in an adult patient with gout when ONE of the following criteria are met:

- The patient has experienced an inadequate treatment response to a maximally titrated dose of allopurinol
- The patient has experienced an intolerance to allopurinol
- Treatment with allopurinol is contraindicated or inadvisable for the patient

Continuation of Therapy

Hyperuricemia

Authorization may be granted when the requested drug is being prescribed for the chronic management of hyperuricemia in an adult with gout when the following criteria is met:



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- The patient has achieved or maintained a positive clinical response since beginning treatment with the requested drug

Approval Duration and Quantity Restrictions:

Initial and Renewal Approval: 12 months

Quantity Level Limits: Reference formulary for specific quantity limits.

References:

1. Uloric [package insert]. Lexington, Massachusetts: Takeda Pharmaceuticals America, Inc.; April 2024.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2024. <https://online.lexi.com>. Accessed October 28, 2024.
3. Micromedex (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: <https://www.micromedexsolutions.com/> (cited: 10/28/2024).
4. FitzGerald JD, Dalbeth N, Mikuls T, et al. 2020 American College of Rheumatology guideline for the management of gout. Arthritis Rheumatol. 2020;72(6):879-895.