UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Chorionic Gonadotropin

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: *(all the following criteria must be met)*

- ❑ Patient is male.
- ❑ Diagnosis of one of the following (please check):
  - ❍ Prepubertal cryptorchidism not due to anatomical obstruction
  - ❍ Hypogonadism secondary to a pituitary deficiency in males
  - ❍ Hypospadias
  - ❍ Kaposi's sarcoma

Re-authorization Criteria:
Updated letter with medical justification or updated chart notes demonstrating positive clinical response.

Initial Authorization: Up to six (6) months
Re-authorization: Up to one (1) year

Note:

- ❖ Not covered for the promotion of fertility, sexual dysfunction, weight loss.

PROVIDER CERTIFICATION
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date