

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

CYCLOSET

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

FAX THIS COMPLETED FORM TO 855-828-4992

CRITERIA FOR CYCLOSET:

- Age > 18 years.
- Diagnosis of Type 2 Diabetes.
- Failure on or contraindication to Metformin.
- May not be used concurrently with a TZD (i.e. Avandia or Actos) or by lactating women.
- Maximum approved dose is 4.8mg daily.

Initial authorization is for 6 months – renewal periods of 1 year require documentation of improvement of A1C and/or fasting plasma glucose.

AUTHORIZATION:

1 year.

RE-AUTHORIZATION:

Updated letter of medical necessity

09/30/2016

<https://medicaid.utah.gov/pharmacy/>