

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

FABRAZYME (agalsidase beta)

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 DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL
NECESSITY TO 855-828-4992**

CRITERIA:

- Documented deficient plasma or leukocyte a-galactosidase A (a-gal) **OR**
- Documented a-gal deficiency and / or mutation in the a-gal A gene in heterozygous females.
- Covered only for patients with documented ADA deficiency

AUTHORIZATION:

6 Months

RE-AUTHORIZATION

Updated letter of medical necessity

02/06/2014

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