

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

HYALURONIC ACID DERIVATIVES

Patient name: _____ Medicaid ID #: _____

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

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

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

Requested Medication: _____ Strength: _____ Frequency: _____

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 for Ophthalmic Preparations:

- Covered only for ophthalmic surgeries (no cosmetic or off-label use). Please indicate the procedure(s) planned and the patient's pertinent diagnosis code(s).
- Authorization is required for each surgical episode (no re-authorization)

CRITERIA for Topical Preparations:

- Covered only for wound care (no cosmetic or off-label use). Please indicate the patient's pertinent diagnosis code(s)
- Authorization = 3 months
- Reauthorization = 3 months, upon submission of a letter of continued necessity, including updated diagnosis codes

CRITERIA for Intra-Articular Preparations:

- Covered only for injection into the knee for the treatment of osteoarthritis (no cosmetic or off-label use, including use in other joints). Please indicate the patient's pertinent diagnosis code(s).
- Please bill using the appropriate product-specific J code.
- Authorization = 1 treatment cycle = 1 injection per week, up to 5 weeks
- Reauthorization = each treatment cycle, upon submission of a letter of continued necessity, including updated diagnosis codes