

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

INSULIN PENS

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:

One or more of the following:

- legal blindness
- debilitating rheumatoid or osteoarthritis of one or both arms, hands, and/or one or more fingers
- other conditions causing severe debilitation of one or both arms, hands, and/or one or more fingers
- reductive deformities of one or both arms, hands, and/or one or more fingers
- Parkinsonism or essential tremor
- mental retardation (severe intellectual disability)
- any condition that necessitates that a patient, greater-than-or-equal-to the age of 19 years, have a legal guardian other than him/herself

Note: patient age of less-than-or-equal-to the age of 18 years is not sufficient justification for approval of insulin pens(s)

Please consider before applying for a PA: Utah Medicaid is happy to replace any insulin vials that a patient may break or otherwise render un-usable.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Updated letter of medical necessity

03/01/2013

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