Medication Coverage Exception

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.

Please select which type of prior authorization you are requesting (check all that apply):

❑ Non-preferred ❑ Brand Name ❑ Combination Product ❑ Dosing Kit
❑ Off-Label Use ❑ Limit Exception ❑ Step Therapy ❑ Other

Non-Preferred Criteria for Approval: *(at least one of the following conditions must be met)*

❑ Trial and failure at an appropriate dose and duration of at least one preferred agent in the drug class.
Medication and dose: _____ Chart Note Page #: _____

Details of failure: _____

❑ Appropriate clinical rationale for prescribing the non-preferred product: *(adverse reaction, allergy, or inadequate response)*

_____ Chart Note Page #: _____

❑ Continuation of Therapy: Member has been treated with the requested non-preferred drug at a consistent dosage for at least 60 days in most recent 90 days and the prescriber indicates the prescribed medication will best treat the member's condition. Details of therapy (including dates):

_____ Chart Note Page #: _____

Brand Name Medication Criterion for Approval:

❑ Appropriate clinical rationale for dispensing the brand name medication instead of the generic:

_____ Chart Note Page #: _____

Combination Product Criteria for Approval: *Utah Medicaid requires the use of multiple single-entity products instead of one combination product, unless the combination is listed as preferred on the Utah Medicaid Preferred Drug List.*

- ❑ Trial and failure of individual agents in the combination product **OR** trial and failure of a preferred agent in each of the combination product's therapeutic drug classes.
  Medication and dose: _____ Chart Note Page #: _____
  Details of failure: _____
- ❑ Appropriate clinical rationale for prescribing the combination product:
  _____ Chart Note Page #: _____

Dosing Kit Criteria for Approval: *Utah Medicaid does not reimburse for dosing kits (e.g., therapy initiation dose titration kits) unless a product is only available in a kit.*

- ❑ Appropriate clinical rationale for prescribing the combination product or kit:
  _____ Chart Note Page #: _____

Dose, Age and/or Quantity Limits Exception Criteria for Approval:

Off label use criterion may apply. Medications with Clinical PA forms such as Opioids, Buprenorphine Products, Antipsychotics in Children, etc. must be submitted on respective Clinical PA forms

- ❑ Member has failed to achieve adequate response within Medicaid's **Quantity/Dose Limit**.
  Medication and dose: _____ Chart Note Page #: _____
  Details of failure: _____
- ❑ Appropriate clinical rationale for prescribing medication outside Medicaid's **Age Limit**:
  _____ Chart Note Page #: _____

Off Label or Compendia Use of FDA-Approved Drugs Criteria for Approval:

- ❑ Requests for any off-label indications must be supported by at least one (1) major multi-site study or three (3) smaller studies published in JAMA, NEJM, Lancet or other peer review specialty medical journals within the most recent five (5) years. Supporting documentation must be included. Compendia use must be recommended by generally accepted compendia such as American Hospital Formulary Service Drug Information (AHFS), United States Pharmacopeia-Drug Information (USP-DI), and the DRUGDEX Information System.
  Diagnosis: _____
  Duration of treatment: _____

Re-authorization Criteria:

Updated letter with medical justification or updated chart notes demonstrating positive clinical response.

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

PROVIDER CERTIFICATION

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

_____ _____
Prescriber's Signature Date