## Medication Coverage Exception Request

### Member and Medication Information (required)

<table>
<thead>
<tr>
<th>Member ID:</th>
<th>Member Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOB:</td>
<td>Weight:</td>
</tr>
<tr>
<td>Medication Name/ Strength:</td>
<td>Dose:</td>
</tr>
</tbody>
</table>

### Directions for use:

### Provider Information (required)

<table>
<thead>
<tr>
<th>Name:</th>
<th>NPI:</th>
<th>Specialty:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Person:</td>
<td>Office Phone:</td>
<td>Office Fax:</td>
</tr>
</tbody>
</table>

All information to be legible, complete and correct or form will be returned. FAX DOCUMENTATION INCLUDING PROGRESS NOTES or UPDATED LETTER OF MEDICAL NECESSITY TO 855-828-4992

**Submission of a request does not guarantee prior approval. Utah Medicaid’s Preferred Drug List is available at [https://medicaid.utah.gov/pharmacy/](https://medicaid.utah.gov/pharmacy/)**

**Member preference does not constitute a medical necessity. (Utah Medicaid Provider Manual, Pharmacy Services Section 4-2)**

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

- [ ] Brand Name  - [ ] Combination Product  - [ ] Dosing Kit  - [ ] Non-preferred  - [ ] Off Label Use
- [ ] Quantity Limits  - [ ] Step Therapy  - [ ] Other

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

1. Trial and failure of at least one preferred agent in the drug class.
   - Medication used: ____________________  Chart Note Page #: ____________________
   - Details of failure: ____________________

2. Detailed evidence of a potential drug interaction between a current medication and the preferred drug.
   - Chart Note Page #: ____________________

3. Detailed evidence of a contraindication that prevents the use of the preferred drug.
   - Chart Note Page #: ____________________

4. Objective clinical evidence that a patient is at high risk of adverse events due to a therapeutic interchange with a preferred drug.
   - Chart Note Page #: ____________________

5. Adverse reaction, allergy or inadequate response to generic equivalent or short-acting generic equivalent.
   - Chart Note Page #: ____________________

Additional Criterion for Brand Name Medication (criterion must be met):

1. Prescriber demonstrates a medical necessity for dispensing the non-generic, brand name, legend drug.

Additional Criterion for Combination Products and Dosing Kits (criterion must be met):

1. Utah Medicaid generally 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. Utah Medicaid does not generally reimburse for dosing kits (e.g. therapy initiation dose titration kits), unless a product is only available in a kit. Provide objective clinical evidence demonstrating the necessity of the combination product or kit.

Additional Criteria for Quantity Limit Requests (all criteria must be met):

1. Has the patient failed to achieve adequate response on the medication within Medicaid’s quantity limits, and were they compliant with that prescribed dosing? ____________________

Last Updated 6/27/2019
2) Include detailed, patient-specific clinical justification for requested dose and consultation notes from a specialist if applicable.
   Chart Note Page #: _______________________

**Additional Criteria for Off Label Use of FDA-approved drugs (all criteria must be met):**

1) Diagnosis Code: _____________________________
2) Duration of treatment: _______________________ 
3) The off-label use 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.
   *For pediatric members, if the above information is unavailable, please include ANY literature that is available, including clinical practice guidelines.

   **Requests for opioids exceeding Utah Medicaid MME limits must be submitted on the Opioids PA form.**
   Requests for opioids which exceed Utah Medicaid quantity limits will be denied.

**Re-authorization Criteria:**
Updated letter of medical necessity or updated chart notes demonstrating positive clinical response.

**Authorization:** 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