

Non-Preferred Authorization Request

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 PROGRESS NOTES AND/OR 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/>

AT LEAST ONE OF THE FOLLOWING CONDITIONS MUST BE MET:

- A trial and failure of at least one preferred agent in the drug class, including the name of the preferred drug that was tried, the length of therapy, and the reason for discontinuation.
- Detailed evidence of a potential drug interaction between current medication and the preferred drug.
- Detailed evidence of a condition of contraindication that prevents the use of the preferred drug.
- Objective clinical evidence that a patient is at high risk of adverse events due to a therapeutic interchange with a preferred drug.

AUTHORIZATION: 1 year

RE-AUTHORIZATION: Updated letter of medical necessity

07/28/2016

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