Rare Disease Medications

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.	

Criteria for Approval (all criteria must be met and documented in submitted chart notes):

- ❑ Medication is prescribed by or in consultation with a physician who specializes in the disease treatment.
  - Specialist name and credentials: _____
- ❑ Documented diagnosis: _____ Chart note page #: _____
  - Genetic testing, if applicable. Chart note page #: _____
  - Other confirmation testing, if applicable. Chart note page #: _____
- ❑ Include latest treatment guidelines or compendia treatment recommendations, if applicable, with request.
- ❑ Use must follow FDA-approved labeling *(including monitoring for boxed warnings and contraindications).*
  - Applicable monitoring for boxed warnings. Chart note page #: _____
- ❑ If current treatment standards recommend other treatment modalities or interventions prior to use of the requested drug, document the use of appropriate first line treatments or interventions.
  - Treatment/Interventions: _____ Chart note page #: _____
- ❑ Off Label or Compendia Use Additional Criteria: 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), the DRUGDEX Information System, and the peer-reviewed medical literature.

Re-authorization Criteria, if applicable:
Updated letter of medical necessity or updated chart notes demonstrating positive clinical response

Initial Authorization: Up to six (6) months, if applicable
Reauthorization: Up to one (1) year, if applicable

Note:

- Use appropriate HCPCS code for billing if applicable
  Coverage and Reimbursement code look up: https://health.utah.gov/stplan/lookup/CoverageLookup.php
  HCPCS NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php

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

_____ _____
Prescriber's Signature Date