

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

**Vpriv** (velaglucerase)

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**

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**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF  
MEDICAL NECESSITY TO 855-828-4992**

**CRITERIA**

- **DOCUMENTED** diagnosis of **Gaucher's Disease**
- Copy of prescription from physician
- Medicaid must be notified of changes in dosage with a copy of a new prescription.

**AUTHORIZATION:**

6 months.

**RE-AUTHORIZATION:**

1 year with documentation of significant improvement

02/06/2014

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