UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Non-Preferred Authorization Request

Member and Medication Information (required)	
Member ID:	Member Name:
DOB:	Weight:
Medication Name/ Strength:	Dose:
Directions for use:	

Provider Information (required)		
Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:

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/

Criteria for Approval:
AT LEAST ONE OF THE FOLLOWING CONDITIONS MUST BE MET:

- ❑ Trial and failure of at least one preferred agent in the drug class:
  Medication used: _____
  Details of failure: _____
  Chart Note Page #: _____
- ❑ Detailed evidence of a potential drug interaction between current medication and the preferred drug.
  Chart Note Page #: _____
- ❑ Detailed evidence of a condition of contraindication that prevents the use of the preferred drug.
  Chart Note Page #: _____
- ❑ 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 #: _____

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