

**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**

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**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.

**NOTE:**

- Do not use this form for Biologics for Rheumatoid Arthritis. Download the appropriate clinical PA form from the Medicaid website.

**AUTHORIZATION:** 1 year

**RE-AUTHORIZATION:** Updated letter of medical necessity

11/07/2013