UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

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.

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

Made Fillable by eForms