UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

ADAGEN (pegademase bovine)

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 **note the new fax number**

CRITERIA:

- **DOCUMENTED** diagnosis of Adenosine Deaminase Deficiency (ADA)
- Copy of prescription from physician
- Dose must be delivered in a pre-filled syringe for exact dosing
- Medicaid must be notified of changes in dosage with a copy of a new prescription.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Updated letter of medical necessity

9/13/10

http://health.utah.gov/medicaid/pharmacy