

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
Adult Acne

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 DOCUMENTATION FROM PROGRESS NOTES OR IN
LETTER OF MEDICAL NECESSITY TO 855-828-4992 note the new fax number**

CRITERIA:

- Diagnosis of acne vulgaris, and/or
- Nodular acne, and/or
- Cystic acne

AUTHORIZATION:

6 months.

RE-AUTHORIZATION:

Documentation indicating patient has had at least a 25% improvement or more from the baseline. Re-authorization is then for 6 months.

09/21/10

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