

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

**REQUEST FOR INJECTABLE ANTI-EMETICS
For Non-Traditional Clients**

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 AND THIS COMPLETED
FORM TO 855-828-4992 note the new fax number**

CRITERIA FOR INJECTABLE ANTI-EMETICS:

Trial and failure of oral anti-emetics

NOTES:

Traditional Medicaid clients do not require clinical prior authorization. Non-Preferred authorization requirements may apply in certain Traditional Medicaid cases.

AUTHORIZATION:

Up to 30 days.

RE-AUTHORIZATION:

Updated letter of medical necessity

8/4/10

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