

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

REQUEST FOR INJECTABLE ANTIBIOTICS

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 ANTIBIOTICS:

- Injectable antibiotics and diluents associated with the preparation and administration of injectable antibiotics are available under the following circumstances:
 - Continuation of treatment that was started in the hospital,
 - Documented diagnosis of cellulitis,
 - Documented diagnosis of osteomyelitis.

- Prior Authorization request **MUST** include an anticipated duration of therapy.

NOTES:

This request form is to be used only for Non-Traditional Medicaid clients (blue card). Traditional Medicaid clients (purple card), in general, do not require clinical prior authorization for IV antibiotic therapy.

AUTHORIZATION:

Prior authorization will be granted for the requested duration of therapy.

RE-AUTHORIZATION:

Updated letter of medical necessity

8/4/10

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