

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

CEREZYME (imiglucerase)

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

- **DOCUMENTED** diagnosis of **Gaucher's Disease**
- Copy of prescription from physician
- Medicaid must be notified of changes in dosage with a copy of a new prescription.

AUTHORIZATION:

6 months.

RE-AUTHORIZATION:

1 year with documentation of significant improvement

9/13/10

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