

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

**CYCLOSET**

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

**CRITERIA FOR CYCLOSET:**

- Age > 18 years.
- Diagnosis of Type 2 Diabetes.
- Failure on or contraindication to Metformin.
- May not be used concurrently with a TZD (i.e. Avandia or Actos) or by lactating women.
- Maximum approved dose is 4.8mg daily.

Initial authorization is for 6 months – renewal periods of 1 year require documentation of improvement of A1C and/or fasting plasma glucose.

**NOTES:**

This form is for Non-Traditional clients (blue card) only. Traditional clients (purple card) may receive this medication without a Prior Authorization.

**AUTHORIZATION:**

1 year.

**RE-AUTHORIZATION:**

Updated letter of medical necessity

8/4/10