

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
CYTOGAM (cytomeglavirus immune globulin)

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 WRITTEN REQUESTS TO 855-828-4992 note the new fax number

CRITERIA:

- For prophylaxis of cytomeglavirus
- **DOCUMENTED** transplantation of kidney, lung, liver, pancreas or heart

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

Updated letter of medical necessity

9/13/10

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