

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

**REQUEST FOR MEDROXYPROGESTERONE ACETATE
(generic Depo Provera)**

For Non-Traditional and PCN 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 THIS COMPLETED FORM TO 855-828-4992 note the new fax number

CRITERIA FOR MEDROXYPROGESTERONE ACETATE:

Patient or provider request injectable medication for family planning.

NOTES:

This form is for Non-Traditional clients (blue card) and Primary Care Network (yellow cards) only. Traditional clients (purple card) may receive this medication without a Prior Authorization.

AUTHORIZATION:

1 year.

RE-AUTHORIZATION:

Updated letter of medical necessity

4/6/11

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