

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

EMBEDA (morphine sulfate/naltrexone)

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**

INITIAL CRITERIA:

- Documented diagnosis of drug abuse, and
- Documented history of chronic pain, and
- No concomitant use of alcohol
- Pain management contract

NOTES:

Please request an NDC change by faxing a note to 855-828-4992

AUTHORIZATION:

Initial 1 year.

RE-AUTHORIZATION:

An updated letter of medical necessity.

9/21/10

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