

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
EMSAM (selegiline transdermal)

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:

- **Physician** documentation from charted progress notes of failure with minimum of three other antidepressants which may include MAOI
- Previous intolerance to oral trial of MAOI
- No concurrent antidepressant therapy

NOTES:

This Prior Authorization is only available to clients enrolled in Traditional Medicaid (Purple Card). Clients enrolled in Non-Traditional Medicaid (Blue Card) or Primary Care Network (Yellow Card) must pay full price for brand name medications with available generics.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Updated letter of medical necessity

9/13/10

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