

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

INSULIN PENS OR CARTRIDGES

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:

Medicaid will only pay for the insulin cartridge or pen for those that are legally blind.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Updated letter of medical necessity

9/15/10

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