

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

**Istodax (romidepsin)**

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**

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**FAX DOCUMENTATION FROM PROGRESS NOTES AND THIS COMPLETED  
FORM TO 855-828-4992 note the new fax number**

**CRITERIA:**

- Minimum age 18 years
- Documented diagnosis of cutaneous T-cell lymphoma
- Documentation of at least one other prior systemic therapy

**NOTE:**

To be paid through HCPCS code to an infusion center or physician's office.

**AUTHORIZATION:**

Initial authorization will be granted for one year.

**RE-AUTHORIZATION:**

Subsequent authorizations will be granted upon submission of an undated letter of medical necessity, showing maintenance or improvement on Isotax.