

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

**LACTULOSE** (enulose)

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 OR IN LETTER OF MEDICAL  
NECESSITY TO 855-828-4992 note the new fax number**

**CRITERIA:**

**DOCUMENTED** Chronic liver failure, Hepatic encephalopathy, Chronic portal hypertension, or Spina bifida.

**INFORMATION:**

- 6000 ml or less per month does not need a prior authorization.
- More than 6000 ml's per month requires an authorization.
- This drug is **not** approved for use as a general laxative over 6000 ml's.

**AUTHORIZATION:**

6 months

**RE-AUTHORIZATION:**

Updated letter of medical necessity

9/15/10

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