

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

OLUX FOAM (clobetasol propionate)

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 TO 855-828-4992 note the new fax number

CRITERIA:

DOCUMENTED failure on generic formulations of Clobetasol Propionate creams, ointments, or solutions within the last 12 months.

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

Updated letter of medical necessity

9/15/10