

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
QUALAQUIN (quinine sulfate)

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:

- Minimum age requirement: 16 years old.
- Diagnosis of malaria.

AUTHORIZATION:

One 7 day course of up to 42 tablets is approved with each PA.

RE-AUTHORIZATION:

Same as initial PA.

9/22/10

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