

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

**Trizivir** (abacavir/lamivudine/zidovudine)

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**

**TO 855-828-4992** note the new fax number

**CRITERIA:**

**DOCUMENTED** failure of all three individual medications: abacavir, lamivudine, zidovudine

**AUTHORIZATION:**

1 year

**RE-AUTHORIZATION:**

Updated letter of medical necessity

9/20/10

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