

UTAH DEPARTMENT OF HEALTH PRIOR AUTHORIZATION REQUEST FORM

XANAX XR (alprazolam)

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 INFORMATION FROM PROGRESS NOTES
TO 855-828-4992 note the new fax number**

CRITERIA:

Trial and failure of a 6-8 week trial of oral, short acting alprazolam within the last 6 months.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Updated letter of medical necessity

9/20/10

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