

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

ZIANA (clindamycin/tretinoin)

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

CRITERIA:

- Age requirement - 12-19 years old.
- Patient must try and fail on a combination of both generic tretinoin gel and clindamycin gel.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Updated letter of medical necessity.

9/20/10

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