

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

ZOVIRAX OINTMENT (acyclovir)

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

AUTHORIZATION CRITERIA:

Fax a letter of medical necessity to 855-828-4992 note the new fax number

SUBSEQUENT AUTHORIZATION CRITERIA IS NOT AVAILABLE

NOTES:

Utah Medicaid patients may only receive one course of treatment with Zovirax ointment per lifetime.