

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
ADAGEN (pegademase bovine)

Patient name: _____ Medicaid or SS# _____
Physician Name: _____ Contact person: _____
Phone#: _____ Ext. and opt. _____ Fax# _____
Pharmacy _____ Pharmacy Phone#: _____

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 (801) 536-0477**

CRITERIA:

- ▶ **DOCUMENTED** diagnosis of Adenosine Deaminase Deficiency (ADA)
- ▶ Copy of prescription from physician
- ▶ Dose must be delivered in a pre-filled syringe for exact dosing
- ▶ Medicaid must be notified of changes in dosage with a copy of a new prescription.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Telephone request from physician's office or pharmacy

