

BRAND NAME MEDICATION

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person _____

Phone#: _____ Ext. and options _____ Fax _____

Pharmacy _____ Pharmacy Phone#: _____

Requested Medication _____

All information to be legible, complete and correct or form will be returned

FAX DOCUMENTATION FROM PROGRESS NOTES TO (801) 536-0477

CRITERIA:

Details of adverse reaction, allergy or inadequate response

AUTHORIZATION:

One year

RE-AUTHORIZATION:

Telephone request from physician's office or pharmacy