

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
CEREZYME (imiglucerase)

Patient name: _____ Medicaid or SS# _____
Physician Name: _____ Contact person: _____
Phone#: _____ Ext. and options _____ 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 **Gaucher's Disease**
- ▶ Copy of prescription from physician
- ▶ Medicaid must be notified of changes in dosage with a copy of a new prescription.

AUTHORIZATION:

6 months.

RE-AUTHORIZATION:

1 year with documentation of significant improvement