

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

**CYTOGAM** (cytomeglavirus immune globulin)

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**

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**TELEPHONE AUTHORIZATION OR WRITTEN REQUEST**

**FAX WRITTEN REQUESTS TO (801) 536-0477**

**CRITERIA:**

- ▶ For prophylaxis of cytomeglavirus
- ▶ **DOCUMENTED** transplantation of kidney, lung, liver, pancreas or heart

**AUTHORIZATION:**

6 months

**RE-AUTHORIZATION:**

Telephone request from physician's office

