

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
EXUBERA (human insulin)

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:

- ▶ Written prior approval obtained by physician
- ▶ 18 years of age or older
- ▶ Not approved for smokers
- ▶ Description of underlying medical necessity which includes a description of the patient's underlying pulmonary condition.
- ▶ Documentation of reason the patient is unable to use short acting insulin. Approval will not be given for patient convenience.
- ▶ Is not being used in combination with short acting insulin (use with long acting is ok)

Authorization:

1 year

Re-authorization:

Letter from physician showing criteria above are still being met

