

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

FLOLAN (epoprostenol)

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person: _____

Phone#: _____ Ext and options _____ Fax# _____

Pharmacy _____ Pharmacy Phone#: _____

Diagnosis _____

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

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN A LETTER OF
MEDICAL NECESSITY TO (801) 536-0477**

CRITERIA:

- ▶ Minimum Age 18 years old
- ▶ Documented diagnosis of Pulmonary Hypertension

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Telephone request from physician's office or pharmacy.