

UTAH DEPARTMENT OF HEALTH PRIOR AUTHORIZATION REQUEST FORM

**LUXIQ FOAM** (betamethasone valerate)

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

**CRITERIA:**

**DOCUMENTED** failure on generic formulations of betamethasone valerate creams or ointments within the last 12 months.

**AUTHORIZATION:**

6 months

**RE-AUTHORIZATION:**

Telephone request from physician's office or pharmacy