

UTAH DEPARTMENT OF HEALTH PRIOR AUTHORIZATION REQUEST FORM

**XANAX XR** (alprazolam)

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 INFORMATION FROM PROGRESS NOTES TO (801) 536-0477**

**CRITERIA:**

- ▶ Must have failed a 6-8 week trial of oral, short acting alprazolam within the last 6 months

**AUTHORIZATION:**

1 year

**RE-AUTHORIZATION:**

Phone call from physician or pharmacy