UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Filsuvez (birch triterpenes)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: (*All* of the following criteria must be met):

1. Is the medication being used to treat wounds associated with dystrophic and junctional epidermolysis bullosa (EB)? ❑ **Yes** ❑ **No**
2. Is the medication being prescribed by or in consultation with a dermatologist? ❑ **Yes** ❑ **No**

Reauthorization Criteria:

1. Has the patient had clinically significant improvement in wound healing? ❑ **Yes** ❑ **No**

Initial Authorization: Up to 6 months

Reauthorization: Up to 1 year

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date