UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Hemady (dexamethasone)

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 patient 18 years of age or older? ❑ **Yes** ❑ **No**
2. Is the medication being used in combination with other anti-myeloma products for the treatment of multiple myeloma? ❑ **Yes** ❑ **No**
   Medication(s) and dose: _____
3. Is the medication being prescribed by or in consultation with a hematologist or oncologist? ❑ **Yes** ❑ **No**
4. Does the patient have documented trial and failure, intolerance, or contraindication to the conventional dexamethasone preparation (i.e., 2mg, 4mg, 6mg)? ❑ **Yes** ❑ **No**
   Rationale: _____
5. Does the provider attest that the patient does not have an active systemic fungal infection? ❑ **Yes** ❑ **No**

Reauthorization Criteria:

1. Has the provider submitted an updated letter with medical justification or updated chart notes demonstrating continued clinical need for Hemady for the treatment of multiple myeloma? ❑ **Yes** ❑ **No**
2. Is the medication still being used in combination with other anti-myeloma products for the treatment of multiple myeloma? ❑ **Yes** ❑ **No**
   Medication(s) and dose: _____

Initial Authorization: Up to six (6) months

Reauthorization: Up to one (1) year

PROVIDER CERTIFICATION

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

_____ _____

Prescriber's Signature Date

For ADA accommodation or assistance completing this form, please call us at 801-538-6155.