HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM

For authorization, please answer each question below and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call Pharmacy Customer Service for assistance at 855-864-1404.

Patient Information	Prescriber Information
Patient Name:	Prescriber Name and Specialty:
Member ID#:	NPI#:
Sex (circle): Male Female	Office Phone: ( ) -
Date of Birth:	Office Fax: ( ) -
Patient Phone: ( ) -	Contact Person:

Diagnosis and Medical Information

Medication:	Strength and Route of Administration:	Frequency:
Height and Weight:	Expected Length of Therapy:	Quantity:
BMI:	Date Calculated: / /	Diagnosis Related to Medication:
Blood Pressure:	Taken on: / /	Drug Allergies:

Rationale for Prior Authorization

History of a medical condition, allergies or other pertinent information requiring the use of this medication:

_____

_____

_____

_____

_____

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_____

Previous use of non-authorized and prior authorized medications tried and failed for this condition:

Name of Medication:	Reason for Failure:	Date of failure:
_____	_____	_____
_____	_____	_____

Prescriber Signature:	Date:

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Updated 06/30/2020