



# Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

## Eucrisa® Prior Authorization Request Form

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:	Dosage Form:	
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information (required)					
<b>Select the diagnosis below:</b>					
<input type="checkbox"/> Mild to moderate atopic dermatitis					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Clinical information:</b>					
Will the requested medication be used chronically? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the member immunocompromised? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received. For urgent or expedited requests please call 1-800-711-4555. This form may be used for non-urgent requests and faxed to 1-855-455-3303.

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