Nevada Medicaid

Submit fax request to: 855-455-3303

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

Nayzilam® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

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:
	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Acute intermittent seizures

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is the member 12 years of age or older? ❑ **Yes** ❑ **No**

Is the medication prescribed by or in consultation with a neurologist? ❑ **Yes** ❑ **No**

Will the dose requested exceed two sprays per seizure cluster, a maximum of one episode treatment every three days, and a maximum treatment of five episodes every month? ❑ **Yes** ❑ **No**

If the request is for **continuation of therapy**, has the member experienced a documented positive clinical response to Nayzilam® therapy? (Attach supporting documentation to request) ❑ **Yes** ❑ **No** ❑ **N/A**

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

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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 1-800-527-0531.