



Nevada Medicaid

Submit fax request to: 855-455-3303

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

Zelnorm® 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:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Irritable bowel syndrome with constipation (IBS-C).	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
Clinical Information	
<input type="checkbox"/> The recipient is female.	
<input type="checkbox"/> The recipient is less than 65 years of age.	
<input type="checkbox"/> The recipient has tried and failed or has a contraindication to Lactulose and/or Polyethylene glycol.	
<input type="checkbox"/> If the request is for continuation of therapy , has the recipient experienced a documented positive clinical response to Zelnorm® therapy? (Attach supporting documentation to request) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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?

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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