



Nevada Medicaid

Submit fax request to: 855-455-3303

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

Medications for Recipients on Hospice 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)
<p>Clinical information:</p> <p>Is the requested medication being used to treat the diagnosis for which the recipient is receiving hospice care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the prescriber verified the recipient is enrolled in the hospice program? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the requested medication being used to treat or manage symptoms of the terminal hospice diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the requested medication providing a curative or long-term prophylactic therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the requested medication not being used for palliative care, but is medically necessary to treat the member? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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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