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)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Clinical information:

Is the requested medication being used to treat the diagnosis for which the recipient is receiving hospice care? ☐ **Yes** ☐ **No**

Has the prescriber verified the recipient is enrolled in the hospice program? ☐ **Yes** ☐ **No**

Is the requested medication being used to treat or manage symptoms of the terminal hospice diagnosis? ☐ **Yes** ☐ **No**

Is the requested medication providing a curative or long-term prophylactic therapy? ☐ **Yes** ☐ **No**

Is the requested medication not being used for palliative care, but is medically necessary to treat the member? ☐ **Yes** ☐ **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.

Office use only: Hospice_NevadaMedicaid_2017Sep-W