



# Nevada Medicaid

Submit fax request to: 855-455-3303

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

## Valtoco® (diazepam) 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 <input type="checkbox"/> Check if request is for initial trial (6 months) <input type="checkbox"/> Check if request is for recertification of therapy (12 months)			Directions for Use:		
Clinical Information (required)					
<b>Select the diagnosis below:</b>					
<input type="checkbox"/> Diagnosis of epilepsy prescribed for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity that are distinct from a patient's usual seizure pattern.					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Drug-Specific Information (required)					
<input type="checkbox"/> Prescribed for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity that are distinct from a patient's usual seizure pattern.					
<input type="checkbox"/> Recipient is six years of age and older.					
<input type="checkbox"/> The medication is being prescribed by or in consultation with a neurologist.					
<input type="checkbox"/> The quantity will not exceed five episodes per month.					
<input type="checkbox"/> For recertification, the recipient has had a positive clinical response to Valtoco® therapy.					

Attach any additional comments, diagnoses, symptoms, medications tried or failed, or 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 1-800-527-0531.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**