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:
❑ Check if requesting brand ❑ Check if request is for initial trial (6 months) ❑ Check if request is for recertification of therapy (12 months)	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ 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.

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

Drug-Specific Information (required)

❑ Prescribed for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity that are distinct from a patient's usual seizure pattern.

❑ Recipient is six years of age and older.

❑ The medication is being prescribed by or in consultation with a neurologist.

❑ The quantity will not exceed five episodes per month.

❑ 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.