Nevada Medicaid

Submit fax request to: 855-455-3303

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

Gimoti® (metoclopramide) Nasal Spray
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 request is for initial trial ❑ Check if request is for recertification of therapy	Directions for Use:	

Clinical Information (required)

Initial Authorization:

❑ The recipient has a diagnosis of acute diabetic gastroparesis.

❑ The recipient is 18 years of age or older.

❑ The recipient does NOT have ANY of the following:

- History of signs or symptoms of tardive dyskinesia (TD)
- History of a dystonic reaction to metoclopramide
- Known or suspected circumstances where stimulation of gastrointestinal (GI) motility could be dangerous (e.g., GI hemorrhage, mechanical obstruction, or perforation)
- Known or suspected pheochromocytoma or other catecholamine-releasing paraganglioma
- Diagnosis of epilepsy or any other seizure disorder
- Hypersensitivity to metoclopramide (e.g., angioedema, bronchospasm)
- Moderate or severe renal impairment (creatinine clearance [CrCl] < 60 mL/minute)
- Moderate or severe hepatic impairment (Child-Pugh B or C)

❑ ONE of the following:

- Adequate (e.g., 2-4 week) trial and failure of oral (e.g., tablet, solution, orally disintegrating tablet) or injectable (e.g., intramuscular) metoclopramide
- The patient is NOT a candidate for oral metoclopramide (e.g., demonstrated or documented erratic absorption of oral medications)

Reauthorization:

❑ The recipient meets all initial authorization criteria.

❑ At least 2 weeks have passed since completion of a previous course of metoclopramide treatment of any dosage form.

❑ Demonstrated improvement in signs and symptoms of diabetic gastroparesis (e.g., nausea, vomiting, early satiety, postprandial fullness, bloating, upper abdominal pain).

❑ Prescriber attestation that the patient is being monitored for extrapyramidal symptoms (e.g., tardive dyskinesia, dystonia) or other serious adverse events (e.g., suicidal ideation, fluid retention).

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.