Print Reset

Nevada Medicaid

General Prior Authorization Form

Fax this form to: 844-347-3202

For the prescribing physician to request prior authorization (PA), when required, for a drug on the Preferred Drug List. Do not use this form for non-preferred drugs or drugs that have their own respective PA forms. For a list of drug-specific PA forms, visit the Nevada Medicaid website: https://nevadamedicaidqa.magellanrx.com/provider/forms.

Date of Request: _____

RECIPIENT INFORMATION

Last Name: _____ First Name: _____

Recipient ID #: _____ Date of Birth: _____

PRESCRIBER INFORMATION

Last Name: _____ First Name: _____

Prescriber NPI: _____ Specialty: _____

Prescriber Phone: _____ Prescriber Fax: _____

Person to contact regarding request: _____

DRUG INFORMATION

Drug Name: _____

Drug Strength: _____ Dosing Frequency: _____

Length of Therapy: _____ Quantity: _____

☐ New Therapy ☐ Renewal If Renewal, date therapy initiated: _____

PREVIOUS DRUG THERAPY

Previous Drug Therapy#1: _____

Strength: _____ Dosing Frequency: _____

Length of Therapy: _____ Quantity: _____

Previous Drug Therapy #2: _____

Strength: _____ Dosing Frequency: _____

Length of Therapy: _____ Quantity: _____

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Last Name: _____ First Name: _____

CLINICAL INFORMATION

1. What is the recipient's diagnosis and ICD-10 code (if applicable)? Please provide diagnostic procedures and findings, including dates.

2. Please provide medical justification for product use:

☐ Attachments

Attestation: I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.

Prescriber Signature: _____ **Date:** _____

(required)

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.

If you have questions, call the Magellan Rx Management Pharmacy Care Center for Nevada Medicaid at 800-695-5526.

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