# Nevada Medicaid – Molina Healthcare
# Zelnorm® Prior Authorization Request Form

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **Please FAX responses to: (844) 259-1689. Phone: (833) 685-2103.**

| **Member Information (required)** | | | **Provider Information (required)** | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Molina 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** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**Select the diagnosis below:**

❑ Irritable bowel syndrome with constipation (IBS-C).

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

**Clinical Information**

❑ The recipient is female.

❑ The recipient is less than 65 years of age.

❑ The recipient has tried and failed or has a contraindication to Lactulose and/or Polyethylene glycol.

❑ If the request is for **continuation of therapy**, has the recipient experienced a documented positive clinical response to Zelnorm® therapy? (Attach supporting documentation to request) ❑ **Yes** ❑ **No** ❑ **N/A**

**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 (833) 685-2103.
This form may be used for non-urgent requests and faxed to (844) 259-1689.