



Nevada Medicaid – Molina Healthcare Protopic® (tacrolimus) 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:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)
<p>Select the diagnosis below:</p> <p><input type="checkbox"/> Moderate to severe atopic dermatitis</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
<p>Clinical information:</p> <p>Will the requested medication be used chronically? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the member immunocompromised? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>For tacrolimus (generic for Protopic) requests, also answer the following:</p> <p>Has the member experienced a side effect, allergy, or treatment failure with the brand formulation of the requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the member experienced therapeutic failure of TWO preferred medications within the same drug class? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list ALL medications: _____</p> <p>Does the member have an allergy, contraindication, drug-to-drug interaction, or a history of unacceptable/toxic side effects with ALL preferred medications within the same drug class? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list ALL medications & allergy/contraindication/interaction/side effects: _____</p> <p>_____</p> <p>Is the non-preferred medication being requested because it is being used for a unique indication that is supported by peer-reviewed literature or an FDA-approved indication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list the unique indications: _____</p> <p>_____</p>

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.

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