



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 <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>		
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 <small>(required)</small>	
Select the diagnosis below:	
<input type="checkbox"/> Irritable bowel syndrome with constipation (IBS-C).	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
Clinical Information	
<input type="checkbox"/> The recipient is female.	
<input type="checkbox"/> The recipient is less than 65 years of age.	
<input type="checkbox"/> The recipient has tried and failed or has a contraindication to Lactulose and/or Polyethylene glycol.	
<input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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.

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