



Nevada Medicaid-Molina Healthcare

Compounded Medication 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:
Ingredients: 1. 2. 3. 4.		
Directions for Use:		

Clinical Information (required)
<p><input type="checkbox"/> Each active ingredient is FDA-approved or national compendia supported for the condition being treated</p> <p><input type="checkbox"/> The therapeutic amounts and combinations are supported by national compendia or peer-reviewed literature for the condition being treated in the requested route of delivery</p> <p><input type="checkbox"/> Any Ingredient that requires prior authorization and/or step therapy have met drug specific criteria as defined in Medicaid Services Manual Chapter 1200 available at the following web address: http://dhcftp.nv.gov/Resources/AdminSupport/Manuals/MSM/C1200/Chapter1200/</p> <p><input type="checkbox"/> The compounded medication is not for cosmetic purpose</p> <p><input type="checkbox"/> No included ingredient has been withdrawn or removed from the market due to safety reasons</p> <p><input type="checkbox"/> The recipient tried and failed therapy or intolerant to at least two FDA-approved, commercially available prescription therapeutic alternatives.</p> <p>Products tried:</p> <p>1.</p> <p>2.</p> <p><input type="checkbox"/> Contraindication to all commercially available products or allergy/sensitivity to inactive ingredient</p> <p><input type="checkbox"/> No commercially available products</p> <p><input type="checkbox"/> No commercially available products in the requested dosage form</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.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of Molina Healthcare. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**