Nevada Medicaid – Molina Healthcare

Doxepin Cream 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 ❑ Check if request is for initial trial ❑ Check if request is for recertification of therapy	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Diagnosis of pruritus with atopic dermatitis.

❑ Diagnosis of lichen simplex chronicus.

❑ Other diagnosis:______________________________ ICD-10 Code(s): ______________________________

Drug-Specific Information (required)

❑ Recipient is 18 years of age and older.

❑ Treatment will not exceed eight days.

❑ The quantity will not exceed 45 grams per month.

Attach any additional comments, diagnoses, symptoms, medications tried or failed, or 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.