



Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Metozolv® ODT (metoclopramide ODT) and Gimoti® nasal spray Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance 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"/> Diabetic gastroparesis (diabetic gastric stasis)	
<input type="checkbox"/> Symptomatic gastroesophageal reflux disease	
<input type="checkbox"/> Postsurgical gastroparesis	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	

Clinical information:
Has the patient had a 30-day trial and failure of Brand Reglan or generic metoclopramide tablet or solution within the last 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No
What is the medical justification for use of metoclopramide nasal spray over oral metoclopramide? _____

Quantity limit requests:
What is the quantity requested per DAY? _____
What is the reason for exceeding the plan limitations?
<input type="checkbox"/> Titration or loading dose purposes
<input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
<input type="checkbox"/> Requested strength/dose is not commercially available
<input type="checkbox"/> Other: _____

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 1-855-401-4262.
 This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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