

**Nascobal<sup>®</sup> Prior Authorization Request Form** DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			<b>Provider Information</b> (required)			
Member Name:			Provider Name:			
Insurance ID#:			NPI#:	IPI#: 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 Fo		orm:
Check if requesting brand			Directions for Use:			
Check if request is for continuation of therapy						
Clinical Information (required)						
Has the patient had a trial and failure of injectable cyanocobalamin within the past 6 months? Decide the Verse Decident No						

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.

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 OptumRx. 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. Office use only: Nascobal\_SouthDakotaMedicaid\_2017May