Prior Authorization Request
Nevada Medicaid – Molina Healthcare

Opioid Quantity Limit

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. **FAX responses to: (844) 259-1689. Phone: (833) 685-2103.**

DATE OF REQUEST:	
MEMBER INFORMATION	
Last Name:	First Name:
Molina ID:	DOB:
PRESCRIBER INFORMATION	
Last Name:	First Name:
NPI:	Specialty:
Phone:	Fax (required):
Person to contact regarding this request:	
MEDICATION INFORMATION	
Drug Name and Strength:	
Quantity:	Dosing:
Diagnosis:	Duration:

COVERAGE CRITERIA

Check all the applicable boxes to indicate each item as true for the recipient:

Must meet all of the following:

- ☐ Recipient has chronic pain or requires an extended opioid therapy and is under the supervision of a licensed prescriber.
- ☐ Pain cannot be controlled through the use of non-opioid therapy (APAP, NSAID's, Antidepressants, anti-seizure medications, physical therapy, etc.).
- ☐ The lowest effective dose is being requested.
- ☐ A pain contract is on file.

OR

Must meet one of the following:

- ☐ Recipient has cancer/malignancy related pain.
- ☐ Recipient is post-surgery with an anticipated prolonged recovery (greater than three months).
- ☐ Recipient is receiving palliative care.
- ☐ Recipient is residing in a long-term care facility.
- ☐ Recipient is receiving treatment for HIV/AIDs.
- ☐ Prescription is written by or in consultation with a pain specialist.

PROVIDER CERTIFICATION – *Prescriber's signature and date required.*

I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.

Prescriber's Signature:_____ Date:_____