# Nevada Medicaid- Molina Healthcare

## Qutenza® (capsaicin)
## 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<br>❑ Check if request is for initial trial<br>❑ Check if request is for recertification of therapy | Directions for Use: | |

## Clinical Information (required)

**Select the diagnosis below:**

- ❑ Diagnosis of neuropathic pain associated with postherpetic neuralgia.
- ❑ Other diagnosis:_____ ICD-10 Code(s): _____

## Drug-Specific Information (required)

- ❑ The recipient has a history of failure or intolerance to over-the-counter capsaicin.

**For recertification:**

- ❑ At least three months have transpired since the last Qutenza® application/administration.
- ❑ The recipient experienced pain relief with a prior course of Qutenza®.
- ❑ The recipient is experiencing a return of neuropathic pain.

**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.