KAISER PERMANENTE®

10315 Professional Circle Reno, NV 89521
Phone: 855-937-5768
Fax: 858-357-2684

PHARMACY PRIOR AUTHORIZATION REQUEST FORM
CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete this form in its entirety and send it to: Kaiser Permanente of Nevada via Fax 858-357-2684

☐ **REQUEST EXPEDITED (URGENT) REVIEW**
By checking this box, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Step Therapy Exemption: This form can be used by the prescribing provider to request a step therapy exemption for patients who qualify under Chapter 689A of Nevada Revised Statues (NRS). Complete the section below and fax documentation.

Is this a request for a Step Therapy Exemption?	**Yes** ☐	**No** ☐
If yes, the prescribing provider must submit the patient's diagnosis (ICD-10 code[s]) and all supporting clinical information. These details are required to determine whether the request qualifies for protections or exceptions under applicable Nevada step therapy laws, including NRS 689A provisions.	**ICD-10 Code(s)**	
	Previously Tried Drugs:	

Patient Information:	**Prescribing Provider Information:**
Patient Name:	Prescriber Name:
Member Number:	Prescriber Fax:
Patient Date of Birth (MM/DD/YYYY):	Prescriber Phone:
Patient Address:	Specialty/Facility Name:
Patient Phone:	Prescriber Office Contact:
Patient Policy/Group:	Prescriber NPI:
	Prescriber DEA:

Requested Drug Information:	☐ New Request	☐ Reauthorization
Patient Diagnosis and ICD-10 Code(s):		
Requested Drug:		
Strength/Route/Frequency:		
Quantity (per month):		
Start Date and Length of Therapy:		
**Other Pertinent Information to Support the Request: Please attach supporting clinical documentation such as chart notes, labs, etc. ** Requests submitted without clinical documentation may be delayed or denied ** **		
Other Medications Tried (Drug names, duration of treatment, and patient response):		
Dispensing Pharmacy Name:		
Pharmacy Phone:	Pharmacy Fax:	
Prescriber or Authorized Signature:		Date: