



Please complete ALL information below and fax your request to 1-888-671-5285

### Nascobal® Prior Authorization Request Form

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Member Information (required)			Provider Information (required)		
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 (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if <b>generic substitution</b> is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>		

Clinical Information (required)
<b>Select the diagnosis below:</b>
<input type="checkbox"/> Competition for vitamin B12 by intestinal parasites or bacteria (e.g., tapeworm, blind loop syndrome)
<input type="checkbox"/> Dietary deficiency of vitamin B12 due to strict vegetarian diet
<input type="checkbox"/> Inadequate secretion of intrinsic factor
<input type="checkbox"/> Inadequate utilization of vitamin B12 (e.g., antimetabolites are employed in treatment of neoplasia)
<input type="checkbox"/> Malabsorption of vitamin B12 due to a structural or functional damage to the stomach or ileum
<input type="checkbox"/> Pernicious anemia with no nervous system involvement
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____

<b>Medication History:</b> Has the patient had an inadequate response to or inability to tolerate oral and sublingual cyanocobalamin? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.

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