FUTURE SCRIPTS

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

Nascobal® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

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

Medication History:

Has the patient had an inadequate response to or inability to tolerate oral and sublingual cyanocobalamin? ❑ **Yes** ❑ **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?

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