# PDL Exception (Non-Preferred Drugs)

**Submit fax request to:** 855-455-3303
**Purpose:** The Nevada Medicaid Preferred Drug List (PDL) lists "preferred" drugs in specific drug categories. Prior authorization is required for non-listed drugs within these categories.
**Questions:** If you have questions, call the OptumRx Call Center for Nevada Medicaid at 855-455-3311.

| | | |
|---|---|---|
| **DATE OF REQUEST:** | | |
| **RECIPIENT INFORMATION** | | |
| Last Name, First Name, Middle Initial: | | Date of Birth: |
| Recipient ID: | Gender: ☐ Male ☐ Female | Phone: |
| **PRESCRIBING PROVIDER INFORMATION** | | |
| Name: | NPI: | |
| Phone: | Fax (required): | |
| Person to contact regarding this request: | | |
| **DIAGNOSIS AND REQUESTED DRUG** | | |
| Applicable ICD-10 code and diagnosis **or** symptom/side effect **(REQUIRED)**: | | |
| Name: | Strength: | ☐ Generic substitution not permitted |
| Dosage: | Duration: | |

**CLINICAL INFORMATION**

Explain recipient's history of allergies or unacceptable side effects experienced with preferred (PDL) medications.

List the preferred (PDL) medications that were tried and failed for the given diagnosis:

| Drug Name | Reason for Failure | Date(s) |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

List any contraindications to or potential drug-drug interactions with the preferred (PDL) medications.

Additional Clinical Information (if applicable):

*Please check the applicable boxes to indicate each item as true for the recipient:*

☐ The non-preferred drug is being requested for a unique indication that is supported by peer-reviewed literature or FDA-approved indication that is unique to the requested drug (document diagnosis above).

☐ The member was recently discharged from a mental health facility on the requested medication. Date:_____

**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:** _____

*This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.*