health information designs

Antibiotics – Resistance Prevention Prior Authorization Form

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for select antibiotics to meet the following criteria:

- Medication must be prescribed by an infection disease specialist, an antibiotic stewardship program, or protocol
- Patient must be of an appropriate age for use per manufacturer label and have a diagnosis of an FDA approved indication for use, proven to be caused by a susceptible microorganism by culture and susceptibility testing
- One of the following must be met:
  - Prescriber must provide evidence-based medical justification for use, explaining why a preferred antibiotic is not an option due to susceptibility, previous failed trials, or other contraindications (subject to clinical review)
  - Patient is continuing treatment upon discharge from an acute care facility

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**Diagnosis for this request:**

Qualifications for coverage:

Has the provider attached documentation showing that the patient's infection is caused by a susceptible microorganism by culture and susceptibility testing?	□ YES □NO
Is the patient continuing treatment upon discharge from an acute care facility?	□ YES □NO
RENEWAL ONLY: Is the patient's condition improving and continued treatment is required after re-evaluation of their condition?	□ YES □NO

Justification for use over preferred agents (provide below or in documentation attached to this request):

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #