Nausea/Vomiting
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 new prescription for a non-preferred agent for nausea/vomiting treatment must meet the criteria for the specified product listed in the preferred drug list (PDL). Please see the PDL at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf:

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

Requested Drug and Dosage:	**Diagnosis for this request:**	
List all failed medications:	**Dates:**	**Reason for Failure:**

Estimated last day of treatment (ie. pregnancy due date or final date of chemotherapy):

Additional Qualifications for Coverage:
□ Does the patient have an inability to tolerate oral medications (please attach swallow study)? □ YES □ NO
□ Other, Explain:

□ *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 #