health information designs

Concurrent Medication Required 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 product on the "Concurrent Medications and Step Care" list must also be taking the required concurrent medication listed in the document. Overrides will be considered for patients that are unable to take the required concurrent medication based on medical justification provided by the prescriber (subject to clinical review by ND Medicaid).

For an override to be considered, please complete and fax in this request form to the above number. Please attach any and all documentation (chart notes, pharmacy print-outs, etc.) supporting a medical justification as to why the patient is unable to use the required concurrent medication.

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 product(s) and frequency of use:	**Diagnosis for this request:**

Medical justification for inability to use required concurrent medication (please attach any supporting documentation 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 #