



**Dispense as Written  
Prior Authorization Form**

<b>Fax Completed Form to: 855-207-0250 For questions regarding this Prior authorization, call 866-773-0695</b>
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Prior Authorization Vendor for ND Medicaid
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North Dakota Medicaid requires that patients receiving a brand name drug, when there is a generic equivalent available, must first try and fail the generic product. The Dispense as Written (DAW1) prior authorization criteria can be found in the Preferred Drug List (PDL) available at [www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf](http://www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf)

**Part I: TO BE COMPLETED BY PRESCRIBER/PRESCRIBER'S OFFICE**

Recipient Name		Recipient Date of Birth	Recipient Medicaid ID Number		
Prescriber Name					
Prescriber NPI		Telephone Number	Fax Number		
Address		City	State	Zip Code	
<b>Requested Drug:</b>	<b>DOSAGE:</b>	<b>Diagnosis for this request:</b>			
<b>QUALIFICATIONS FOR COVERAGE:</b>		<b>Start Date</b>	<b>End Date</b>	<b>Dose</b>	<b>Frequency</b>
<b>ADVERSE REACTION TO GENERIC EQUIVALENT:</b> <input type="checkbox"/> FDA MEDWATCH FORM ATTACHED FOR EACH GENERIC FAILED					
<b>PRIMARY INSURANCE REQUIRES:</b> <input type="checkbox"/> BRAND NAME PRODUCT					
Primary insurance carrier: _____					
<input type="checkbox"/> 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 #