health information designs

Diabetic Testing Supplies 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

In line with current ADA guidelines, ND Medicaid requires that patients receiving a prescription for diabetic testing supplies that are not receiving an insulin or sulfonylurea product, as evidenced by paid pharmacy claims, will require prior authorization to qualify for coverage.
Overrides for a period of 6 months will be considered for patients that are newly diagnosed, acutely ill, or have a significant change in health status for medically necessary purposes. To obtain an override, please complete this form and fax to the number above for clinical review.

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 use/ qualifications for coverage (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 #