health information designs

General
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 non-preferred medications to meet specific diagnosis and step-therapy requirements. Criteria for agents requiring prior authorization can be found at one of the following locations:

- The Preferred Drug List (PDL) available at www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf
- Prior Authorization Criteria available at www.hidesigns.com/assets/files/ndmedicaid/2018/Criteria/PA_Criteria.pdf

*****Completed Medwatch form(s) must be attached to this request for failed trial(s) in which the active ingredient of the failed product is the same as the requested product*****

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:**		
List all failed medications:		**Start Date:**	**End Date:**

Additional Qualifications for Coverage (e.g. medical justification explaining inability to meet required trials)

□ Patient is pregnant: Due Date _____
□ Patient has inability to take or tolerate solid oral dosage forms (please attach swallow study)
□ Patient has feeding tube in place: (please state specific type of feeding tube _____)
□ Other: (please fill out below)

□ *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 #