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 Medicaid

ND Medicaid requires that members 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 the following location:

- The Preferred Drug List (PDL) is available at www.hidesigns.com/assets/files/ndmedicaid/NDPDL.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 PRESCRIBER REPRESENTATIVE

Member Name	Member Date of Birth	Member Medicaid ID Number	
Prescriber Name	Prescriber/Rendering NPI	Billing NPI *(medical billing only)*	
Specialist involved in therapy *(if not treating physician)*	Telephone Number	Fax Number	
Reason for PA request:	Member Weight	Adjusted Weight	BMI
Requested Drug and Dosage:	**Diagnosis for this request:**		
List all failed medications:		**Start Date:**	**End Date:**

Additional Qualifications for Coverage:
□ Member is pregnant: Due Date _____
□ Member has primary insurance requiring requested product
□ Member is unable to use preferred dosage form (please provide medical justification below– e.g. contraindication, feeding tube, permanent disability, temporary restriction, swallow study, etc.)

□ *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 member.*

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 member'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 #