health information designs

NSAIDs
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 using non-preferred NSAIDs must meet the following criteria:

- **For generic non-preferred, solid oral dosage form NSAIDs:**
  - Patient must have failed a 30-day trial of 3 oral generic NSAIDs, as evidenced by paid claims or pharmacy print outs
- **For Branded NSAIDs**
  - Provider must submit medical justification explaining why the patient cannot use all other NSAIDs (subject to clinical review)
- **For Sprix**, please see additional prior authorization criteria for NSAIDs available at **www.hidesigns.com/assets/files/ndmedicaid/2018/Criteria/PA_Criteria.pdf**
- **For Combination NSAIDs:**
  - Provider must submit medical justification explaining individual ingredients cannot be used separately (subject to 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
Requested Drug and Dosage:	**Diagnosis for this request:**	

List all failed medications:	**Start Date:**	**End Date:**	**Reason for Failure:**

Qualifications for coverage:

Is the patient unable to ingest solid dosage forms (please attach swallow study documentation)?	□ YES □NO
Does the patient have a history of gastric or duodenal ulcer or comorbidities of GI bleed, perforation, or obstruction?	□ YES □NO
For Sprix Requests: Does patient have a diagnosis of postoperative nausea and vomiting?	□ YES □NO
All other needed qualifications for coverage/medical justification for use is attached to this request?	□ YES □NO

□ *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 #