health information designs

Non-Preferred Dosage Forms
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 dosage form of a preferred agent must meet the following prior authorization criteria:

- The prescriber must submit medical justification explaining why the patient cannot use the preferred product (subject to clinical review)
- Patient must have FDA approved indication for use
- Patient must not have contraindications to requested product
- Patient must have failed a therapeutic course of all preferred agents within the last 2 years
  - Trials must have been at least 30 days in duration unless otherwise indicated
  - A failure is defined as product was not effective at maximum tolerated dose or patient has a documented intolerance or adverse reaction to inactive ingredients where the non-preferred product is expected to have a different result and other alternatives (e.g. medications in same class) are not an option for the patient

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:**

• **Does the patient have any contraindications to therapy with the requested agent?**	□ YES □ NO
• **Is medical justification explaining why the patient cannot use the preferred product attached?** *(please attach any relevant documentation to the 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 #