OUT OF STATE PHARMACY FORM

health information designs

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

Part I

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number

Requested Drug and Dosage:

Qualifications for coverage:

Start Date	End Date	Dose	Frequency

Reason for out of state pharmacy request:

Recipient is residing out of state? □ YES □ NO
If yes, please provide recipient residence, city, state, zip code:

Requested drug is only available at out of state pharmacies? □ YES □ NO

Third party requires out of state pharmacy for coverage? □ YES □ NO
If yes, contact State Provider Relations at 1-800-755-2604.

Part II

PHARMACY NAME (REQUIRED)			ND MEDICAID PROVIDER NUMBER (REQUIRED)
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC # (REQUIRED)

Pharmacy Signature:	Date:

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	