Prior Authorization Vendor for ND Medicaid

# Topical Anesthetics
# Prior Authorization Form

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

ND Medicaid requires that patients receiving a new prescription for topical anesthetic must meet the following criteria:

- **These medications will only be covered when prescribed for use prior to certain procedures (e.g., placement of a peripheral or central line or injections through an implanted port). Medical procedure must be listed on PA form.**
- **PA not required for patients 12 years of age and younger.**

**Part I: TO BE COMPLETED BY PHYSICIAN**

| Recipient Name | Recipient Date of Birth | Recipient Medicaid ID Number | |
|---|---|---|---|
| Prescriber Name | | | |
| Prescriber NPI | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:** | **FDA approved indication for this request:**<br>□ Placement of a peripheral or central line<br>□ Injections through an implanted port<br>□ Other: | | |
| **Is the requested agent being given used at the patient's residence?** | | □ YES □ NO | |
| 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 # |