



Asacol HD Prior Authorization

**Fax Completed Form to:
866-254-0761
For questions regarding this
Prior authorization, call
866-773-0695**

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Asacol HD must try and fail Asacol.

***Note:**

- *Asacol is FDA approved to treat mild to moderate flares and maintain remission of ulcerative colitis.*
- *Asacol HD is FDA approved to treat flares in patients with moderately active ulcerative colitis.*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name		Recipient Date of Birth		Recipient Medicaid ID Number	
Physician Name					
Physician Medicaid Provider Number			Telephone Number		Fax Number
Address			City		State Zip Code
Requested Drug and Dosage: <input type="checkbox"/> Asacol HD			Diagnosis for this request:		
Qualifications for coverage: <input type="checkbox"/> FAILED ASACOL THERAPY					
START DATE:			DOSE:		
END DATE:			FREQUENCY:		
Physician Signature				Date	

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:		
PHONE NUMBER	FAX NUMBER	DRUG	NDC #		

Part III: FOR OFFICIAL USE ONLY

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