Prior Authorization Vendor for ND Medicaid

BRAND NAME NSAID/COX-II PA FORM

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

ND Medicaid requires that patients using brand name NSAIDs or COX-II drugs must use a generic NSAID as first line.
*Note: **The PA will be approved if one of the following criteria is met:**

- **Failed two trials of prescribed NSAID**
- **Recipient is on warfarin or corticosteroid therapy**
- **Recipient has history of gastric or duodenal ulcer or has comorbidities of GI bleed, perforation or obstruction**
- **Recipient has history of endoscopically documented NSAID induced gastritis with GI bleed**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**Diagnosis for this request:**	
□ Celebrex	□ Warfarin/Corticosteroid therapy	□ GI bleed, perforation or obstruction
□ Other ___________________	□ Gastric or duodenal ulcer	□ Endoscopically documented NSAID gastritis with GI Bleed

Qualifications for coverage:

□ Failed NSAID therapy	Start Date	End Date	Dose	Frequency
□ Failed NSAID therapy	Start Date	End Date	Dose	Frequency

□ *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 Signature	Date

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE 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)	