



BRAND NAME NSAID/COX-II PA FORM

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 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 oral NSAIDs to receive brand name oral NSAIDs
- Failed trial of Voltaren gel to receive brand name topical NSAIDs for inflammation
- 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
- Solaraze will be covered for patients with a diagnosis of actinic keratoses

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: <input type="checkbox"/> Celebrex <input type="checkbox"/> Other _____ | | Diagnosis for this request: <input type="checkbox"/> Warfarin/Corticosteroid therapy <input type="checkbox"/> GI bleed, perforation or obstruction <input type="checkbox"/> Gastric or duodenal ulcer <input type="checkbox"/> Endoscopically documented NSAID gastritis with GI Bleed <input type="checkbox"/> Actinic keratoses (Solaraze) | | | |
| Qualifications for coverage: | | | | | |
| <input type="checkbox"/> Failed NSAID therapy | Start Date | End Date | Dose | Frequency | |
| <input type="checkbox"/> Failed NSAID therapy | Start Date | End Date | Dose | Frequency | |
| <input type="checkbox"/> 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

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|------------------|------------|------|------------------------------|--|--|
| 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) | | | | | |