



**DISPENSE AS WRITTEN
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

North Dakota Medicaid requires that patients receiving a brand name drug, when there is a generic equivalent available, must first try and fail the generic product for one of the following reasons.

- **The generic product was not effective**
- **There was an adverse reaction with the generic product**

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: | DOSAGE: | Diagnosis for this request: | | | |
| QUALIFICATIONS FOR COVERAGE: <input type="checkbox"/> FAILED GENERIC EQUIVALENT | | Start Date | End Date | Dose | Frequency |
| ADVERSE REACTION TO GENERIC EQUIVALENT (ATTACH FDA MEDWATCH FORM) OR CONTRAINDICATED (PROVIDE DESCRIPTION): | | | | | |
| <input type="checkbox"/> <i>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.</i> | | | | | |
| 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) | |