



**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,**
- **DAW not allowed for drugs with an authorized generic available.**

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