

## METOZOLV ODT 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 receiving a new prescription for Metozolv must meet the following criteria:

- **Patient must try metoclopramide.**

**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
<b>Requested Drug and Dosage:</b> <input type="checkbox"/> METOZOLV			<b>Diagnosis for this request:</b>		
<input type="checkbox"/> <b>FAILED METOCLOPRAMIDE THERAPY</b>		<b>START DATE</b>	<b>END DATE</b>	<b>DOSE</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>					
Physician 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)					