

MOXATAG 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 Moxatag must submit documentation of allergies or show a history of intolerable side effects to the inactive ingredients in regular-release amoxicillin.

- Regular-release amoxicillin does not require a prior authorization.

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
REQUESTED DRUG : <input type="checkbox"/> MOXATAG			Dosage		
Qualifications for coverage:					
<input type="checkbox"/> Allergic/intolerable side effects to inactive ingredients of regular-release amoxicillin. Name of inactive ingredient: _____			Diagnosis for this request:		
<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.					
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)					