



**Nexiclon Prior Authorization**

**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 Nexiclon must try and fail clonidine.

**\*Note:**

- **Clonidine does not require PA**

**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"/> Nexiclon			<b>Diagnosis for this request:</b>		
<b>Qualifications for coverage:</b> <input type="checkbox"/> FAILED CLONIDINE THERAPY					
START DATE:		DOSE:			
END DATE:		FREQUENCY:			
Physician Signature				Date	

**Part II: TO BE COMPLETED BY PHARMACY**

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:		
PHONE 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)					