



**Orally Disintegrating Tablets (ODT)
Prior Authorization**

Fax Completed Form to: 866-254-0761 For questions regarding this Prior authorization, call 866-773-0695
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Prior Authorization Vendor for ND Medicaid
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ND Medicaid requires that patients who are prescribed an orally disintegrating tablet must first try a more cost-effective dosage form.

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 and Dosage:			Diagnosis for this request:		
Qualifications for coverage:					
<input type="checkbox"/> Unable to Swallow <input type="checkbox"/> Medication Failed					
		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)					