



**OPHTHALMIC ANTI-INFECTIVE
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 will not pay for Azasite or Quixin without documented failure of a first line antibiotic ophthalmic agent.

***Note: First line agents include sulfacetamide (Bleph 10[®], etc.), erythromycin, bacitracin-polymixin B (Polysporin[®]), polymyxin B neomycin-gramicidin (Neosporin[®]), trimethoprim-polymyxin B (Polytrim[®]), gentamicin (Garamycin[®], etc.), ofloxacin (Ocuflox[®]) and ciprofloxacin (Ciloxan[®]).**

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
Requested Drug and Dosage: <input type="checkbox"/> AZASITE <input type="checkbox"/> QUIXIN		Diagnosis for this request:			
<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:
Denied: (Reasons)					