



DORYX and ORACEA 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

Note: ND Medicaid will not pay for Oracea without documented failure of a first line tetracycline agent.

- First line agents include: doxycycline, minocycline, and tetracycline.

Part I: TO BE COMPLETED BY PRESCRIBER

RECIPIENT NAME: Recipient Date of birth: / /		RECIPIENT MEDICAID ID NUMBER:	
PRESCRIBER NAME:		PRESCRIBER MEDICAID ID NUMBER:	
Address:		Phone: ()	
City:		FAX: ()	
State:	Zip:		
REQUESTED DRUG: <input type="checkbox"/> ORACEA <input type="checkbox"/> DORYX		Requested Dosage: (must be completed)	
Qualifications for coverage: <input type="checkbox"/> Patient has failed a 90 day trial of which first line agent _____			
<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.			
Prescriber Signature:		Date:	

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Part III: FOR OFFICIAL USE ONLY

Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	