

**ORAL ANTICOAGULANTS  
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 Pradaxa or Xarelto must meet the following criteria:

- **Patient must have an FDA approved indication.**

**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"/> PRADAXA <input type="checkbox"/> XARELTO		<b>Diagnosis for this Request:</b>			
<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:    /    /			Approved by:		
Denied: (Reasons)					