



**Oravig 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 prescription for Oravig first try fluconazole.

**\*Note:**

- **Fluconazole 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
Requested Drug and Dosage: <input type="checkbox"/> Oravig			Diagnosis for this request:		
Qualifications for coverage:					
<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)					