RIBAPAK PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for RibaPak must meet the following criteria:

- **Patient must first try Ribavirin or Ribasphere.**

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: □ RIBAPAK	**FDA Approved Indication for this request:**			
□ **Failed therapy with Ribavirin or Ribasphere**	**Start Date**	**End Date**	**Dose**	
WHAT IS THE HCV GENOTYPE? (I-IV)				
***TREATMENT WILL BE COVERED FOR 24 TO 48 WEEKS BASED UPON GENOTYPE AND DIAGNOSIS.**				
□ Treatment regimen for Hepatitis C will include pegylated or non-pegylated interferon in combination with oral ribavirin.				
Physician 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)	