



Zanaflex Capsule 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 Zanaflex capsules must use tizanidine tablets first line.

***Note:**

- Tizanidine tablets do not require a PA.
- Patient must fail therapy on tizanidine tablets before a PA may be granted.

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:		Diagnosis for this request:			
Qualifications for coverage:					
<input type="checkbox"/> Failed generic drug		Start Date:		Dose:	
		End Date:		Frequency:	
<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 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)					