



Zyclara 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 Zyclara first try imiquimod.

\*Note:

- Imiquimod does not require PA

Part I: TO BE COMPLETED BY PHYSICIAN

Form with fields: 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 (Zyclara), Diagnosis for this request, Qualifications for coverage (Trial of imiquimod), Start Date, End Date, Physician Signature, Date.

Part II: TO BE COMPLETED BY PHARMACY

Form with fields: PHARMACY NAME, ND MEDICAID PROVIDER NUMBER, PHONE NUMBER, FAX NUMBER, DRUG, NDC #.

Part III: FOR OFFICIAL USE ONLY

Form with fields: Date Received, Initials, Approved - Effective dates of PA (From: / / To: / /), Approved by, Denied: (Reasons).