

BRAND-NAME NARCOTICS 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 a brand-name narcotic must meet the following criteria:

- **Documented failure of a 30-day trial of a generic narcotic.**

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"/> EMBEDA <input type="checkbox"/> OPANA ER <input type="checkbox"/> KADIAN <input type="checkbox"/> AVINZA <input type="checkbox"/> EXALGO <input type="checkbox"/> FENTORA <input type="checkbox"/> ONSOLIS <input type="checkbox"/> MAGNACET <input type="checkbox"/> BUTRANS <input type="checkbox"/> OTHER BRAND NAME PRODUCT _____					
FAILED THERAPY	START DATE	END DATE	DOSE	FREQUENCY	
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)					