

TRAMADOL ER 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 tramadol ER (Ultram ER/Ryzolt) or tramadol ODT (Rybix) must meet the following criteria:

- **Documented failure of a 30-day trial of generic immediate release tramadol at maximum daily dosage of 400mg per day.**

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:			Diagnosis for this request:		
<input type="checkbox"/> ULTRAM ER OR GENERIC <input type="checkbox"/> RYZOLT <input type="checkbox"/> RYBIX					
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)		