# GENERIC NON-PREFERRED PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form**
**Attention: Pharmacy**
**1-701-328-1544**

North Dakota Medicaid requires that patients receiving a generic non-preferred drug, when there is a brand preferred equivalent available, must first try and fail a brand equivalent preferred agent.

- **The brand product was not effective (attach MedWatch form)**
- **There was an adverse reaction with the brand product (attach MedWatch form)**
- **Primary insurance requires a ND Medicaid non-preferred generic product.**

**Part I: TO BE COMPLETED BY PRESCRIBER**

| Recipient Name | | Recipient Date of Birth | Recipient Medicaid ID Number | |
|---|---|---|---|---|
| Prescriber Name | | | | |
| Prescriber NPI | | Telephone Number | Fax Number | |
| Address | | City | State | Zip Code |
| **Requested Drug:** | **DOSAGE:** | **Diagnosis for this request:** | | |

| **QUALIFICATIONS FOR COVERAGE:** □ FAILED A PREFERRED BRAND EQUIVALENT AGENT | **Start Date** | **End Date** | **Dose** | **Frequency** |
|---|---|---|---|---|

**ADVERSE REACTION TO BRAND EQUIVALENT:** □ FDA MEDWATCH FORM ATTACHED FOR EACH THERAPEUTICALLY EQUIVALENT AGENT FAILED

**PRIMARY INSURANCE REQUIRES:** □ GENERIC NON-PREFERRED PRODUCT

Primary insurance carrier: _____

□ *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 (or Staff) / Pharmacy 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |