North Dakota Workforce Safety & Insurance

PROVIDER'S REQUEST FOR MEDICATION PRIOR AUTHORIZATION

MEDICAL SERVICES DIVISION
SFN 58430 (06/2017)

1600 E Century Ave, Ste 1
PO Box 5585
Bismarck ND 58506-5585
Telephone 800-777-5033
Toll Free Fax 888-786-8695
TTY (hearing impaired) 800-366-6888
Fraud and Safety Hotline 800-243-3331
www.workforcesafety.com

SECTION 1 – *Injured worker information*

Claim number	Injured worker's (First name)	(Last name)
Date of birth		Date of request

SECTION 2 – *Provider information*

Provider's (First name)	(Last name)	NPI number
Business or facility name		
Telephone number	Fax number	
Address		
City	State	ZIP code

SECTION 3 – *Medication information*

Medication name	Strength	Dosage form
Diagnosis for this request		

Select one of the following reasons for the request

☐ Prior authorization for medication, medication dosage, or medication interval
Describe reason for request and duration of need

☐ Prior authorization for brand medication
Has injured worker tried a generic?
☐ Yes*
☐ Adverse reaction
☐ Inadequate response

☐ No

***Include medical notes from injured worker's file detailing objective medical evidence of the adverse reaction and/or inadequate response to the generic equivalent medication.**

SECTION 4 – *Signature*

I certify that the above prescribed medication is medically necessary for this patient's well-being. In my opinion, this is reasonable and necessary in conformance with accepted standards of medical practice for the treatment of this condition. This medication is not prescribed as a convenience to the patient or solely due to the request of the patient.

Provider's signature	**Date**

Fax this authorization form and supporting documentation to 888-786-8695

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