



**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		
<p>Select one of the following reasons for the request</p> <p><input type="checkbox"/> Prior authorization for medication, medication dosage, or medication interval Describe reason for request and duration of need</p> <p><input type="checkbox"/> Prior authorization for brand medication Has injured worker tried a generic? <input type="checkbox"/> Yes* <ul style="list-style-type: none"> <input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> No</p> <p>*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.</p>		
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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