Acentra HEALTH

Prior Authorization Vendor for ND Medicaid

**Asthma and COPD**
**Prior Authorization Form**

**Fax completed form to:**
**855-207-0250**
**For questions regarding this prior authorization, call**
**866-773-0695**

ND Medicaid requires that members receiving a prescription for non-preferred agents, biologics, and Trelegy to meet specific clinical criteria for coverage which can be found at https://ndmedicaid.acentra.com/ndpdl/

| Member Name | Member Date of Birth | Weight (kg) | Member Medicaid ID Number |
|---|---|---|---|
| Prescriber Name | Prescriber NPI | Specialist involved in therapy *(only applicable if criteria requires)* | |
| Telephone Number | Fax Number | Address | |
| **Diagnosis for the Request:** | City | State | Zip Code |
| **Requested Drug, Strength, and Directions:** | | **Dosage Form (e.g., tablet):** | |

**SECTION A: Biologics**

*Anti-IL-5 biologics only:*

1. Does the member have eosinophilic phenotype with eosinophil count ≥ 150 cels/mcL within the past 90 days? ☐ YES ☐ NO

*Eosinophil directed biologics only:*

1. Is the member's securem total IgE level, measured before the start of treatment, of ≥ 30 IU/mL and ≤ 700 IU/mL in members age ≥ 12 years or ≥ 30 IU/mL and ≤ 1300 IU/mL in members ages 6 to < 12 years? ☐ YES ☐ NO
2. Has the member had a positive skin test or in vitro reactivity to a perennial aeroallergen? ☐ YES ☐ NO

**SECTION B: Inhaled Corticosteroids, HFA products and QVAR Redihaler**

1. Inspiratory flow rate: _____
2. Does the member have a permanent disability preventing use of a dry powder inhaler? ☐ YES ☐ NO
   a. If yes, please explain how the member's permanent disability prevents them from being able to use DPI inhalers:

_____

| **List all failed medications:** | **Start Date:** | **End Date:** |
|---|---|---|
| | | |

**Clinical justification explaining why the member is unable to use preferred products** *(only applicable if criteria requires)*

**Renewal Requests only: assessment of the member's clinical benefit since starting the requested agent (e.g., change in asthma exacerbation, use of rescue medications)**

☐ *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 member.*

| Prescriber (or Staff) / Pharmacy Signature** | Date |
|---|---|
| | |

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*