Duchenne Muscular Dystrophy
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a new prescription for Duchenne muscular dystrophy must meet the agent criteria located on the Preferred Drug List (PDL), located on the North Dakota Department of Human Services Prior Authorization website at http://www.hidesigns.com/ndmedicaid. Please fill out this request form in its entirety, answer all questions relevant to the requested product, and attach any required documentation to this request form.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Prescriber NPI		
Billing Facility NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Billing Facility NPI	ICD-10 Code:		
Requested Drug:			
Diagnosis for this request:			
Patient's weight:	**Calculated dose:**		
Has all required documentation been attached to the request (e.g. genetic testing, formal consultation, 6MWT, FVC, LVEF)?	**□ YES □ NO**		
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 patient'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.*