Acentra HEALTH

GLP-1 Agonist and GIP/GLP-1 Agonist 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 Medicaid

ND Medicaid requires that members receiving a prescription for non-preferred medications to meet specific criteria for coverage found at https://ndmedicaid.acentra.com/ndpdl/

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

Diagnosis for this request (select all that apply):
☐ Type 2 Diabetes – go to **section A**
☐ Reduction of Major Adverse Cardiovascular Events (MACE) – go to **section B**
☐ Weight loss/obesity *(please note, GLP-1 agonists and GIP/GLP-1 agonists are not covered for weight loss/obesity)*
☐ Antipsychotic induced weight gain *(Victoza and metformin are covered for this indication without prior authorization)*

Section A: Type 2 Diabetes

1. Member's current A1c or time-in-range: _____ (Date: _____)
2. Please provide a list of all failed medications (If the member is unable to complete trial requirements with preferred agents, please provide clinical justification explaining why, including mitigation efforts trialed to minimize adverse effects)

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

Section B: Reduction of MACE

1. Member's current A1c: _____ (Date: _____)
2. Initial BMI: _____
3. Does the member have history of the following (select all that apply):
   ☐ Myocardial infarction (MI)
   ☐ Stroke
   ☐ Peripheral arterial disease (PAD)), as evidenced by intermittent claudication with ankle-brachial index <0.85, peripheral arterial revascularization procure, or amputation due to atherosclerotic disease
4. *For member's using tobacco:* Does the member receive tobacco cessation counseling? ☐ YES ☐ NO

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

Renewal Requests only: assessment of the member's clinical benefit since starting the requested agent

☐ *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.*