health information designs

Gamifant
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 Gamifant 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	
Specialist involved (if not treating physician)	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug:	Diagnosis:	ICD-10 Code:

Prior therapies	**Start-end dates**	**Reason for discontinuation**

Is the patient a candidate for stem cell transplant?	□ **YES**	□ **NO**
Does the patient experience the following clinical characteristics?		
• Fever ≥101.3°F for > 7 days	□ YES	□ NO
• Splenomegaly	□ YES	□ NO
• Low or absent natural killer cell activity	□ YES	□ NO
• Ferritin ≥ 500 mg/L	□ YES	□ NO
• Soluble CD25 (i.e., soluble IL-2 receptor) ≥ 2,400 U/mL	□ YES	□ NO
• Fasting triglycerides ≥ 265 mg/dL (2 mmol/L)	□ YES	□ NO
• Fibrinogen ≤ 1.5 g/L	□ YES	□ NO
• ANC <1000/microL	□ YES	□ NO
• Platelet count < 100,000/microL	□ YES	□ NO
• Hemoglobin < 9 g/dL (or < 10 g/dL in infants < 4 weeks of age)	□ YES	□ NO
Has all required documentation been attached to the request (e.g. genetic testing, lab documentation)?	□ **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.*