Acentra HEALTH

Prior Authorization Vendor for ND Medicaid

General
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 medications to meet specific criteria for coverage found at https://ndmedicaid.acentra.com/ndpdl/

Documentation required: ***Completed MedWatch form(s) must be attached to this request for failed trial(s) of each NDC in which the active ingredient of the failed product is the same as the requested product***

Member Name	Member Date of Birth	Member Medicaid ID Number	
Prescriber Name	Prescriber/Rendering NPI	Billing NPI *(medical billing only)*	
Address	City	State	Zip Code
Specialist involved in therapy *(only applicable if criteria requires)*	Telephone Number	Fax Number	
Diagnosis for this request: ☐ Off-label	Member Weight (kg)	Adjusted Weight (kg)	BMI
Requested Drug, Strength, and Directions:		**Dosage Form (e.g., tablet):**	
List all failed medications:		**Start Date:**	**End Date:**

Additional Qualifications for Coverage:
☐ Member is pregnant: Due Date _____
☐ Member has primary insurance requiring requested product
☐ Member is unable to use preferred dosage form (please provide medical justification below– e.g. contraindication, feeding tube, permanent disability, temporary restriction, swallow study, etc.)
☐ Member uses tobacco: Has the member received tobacco cessation counseling in the past year? ☐ 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.*