Acentra HEALTH

Phenylketonuria Agents
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 new prescription for a phenylketonuria agent must specific clinical criteria for coverage which can be found at https://ndmedicaid.acentra.com/ndpdl/

- **Documentation required:** evidence of compliance with a PHE restricted diet for past 6 months (documentation must be submitted along with the request, e.g., chart notes)

Member Name	Member Date of Birth	Weight (kg)	Member Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (only applicable if criteria requires)			
Prescriber NPI	Telephone Number		Fax Number	
Address	City		State	Zip Code
Requested Drug, Strength, and Directions:			**Dosage Form (e.g., tablet):**	
Diagnosis for this Request:	**Baseline PHE level (initial request):**		**Current PHE level (renewal requests or Palynziq requests):**	

List all failed medications (drug name, date of trial, reason for failure):

Qualifications for Coverage:

1. Is the member of child-bearing potential?	☐ YES	☐ NO
2. Has the member been compliant with diet and medications for the past 6 months?	☐ YES	☐ NO
3. Has the member been known to have two null mutations in TRANS?	☐ YES	☐ NO

☐ *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.*