



Mifeprex
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 Mifeprex must meet the following criteria:

- Member must have an FDA approved indication for the medication requested.
- Prescriber must provide signed written statement as listed in the Mifeprex Prior Authorization Criteria at www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf

Part I: TO BE COMPLETED BY PRESCRIBER REPRESENTATIVE

Member Name		Member Date of Birth		Member Medicaid ID Number	
Prescriber Name					
Prescriber Medicaid Provider Number			Telephone Number		Fax Number
Address			City		State Zip Code
Requested Drug and Dosage:			FDA approved indication for this request:		
<ul style="list-style-type: none"> • Is the member terminating a pregnancy before 70 days of gestation? <input type="checkbox"/> YES <input type="checkbox"/> NO • Is the member resulting from an act of rape or incest? <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, please attach written statements as outlined in section 1 below) • Does the woman suffer from a physical disorder that would place the woman in danger of death unless abortion is performed? <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, please attach a written statement as outlined in section 2 below) <p>Section 1:</p> <ul style="list-style-type: none"> • The provider has provided a signed written statement indicating that the rape or act of incest has been reported to the appropriate law enforcement agency, or in the case of a minor who is a victim of incest, to an agency authorized to receive child abuse and neglect reports. The statement must indicate to whom the report was made. • The provider has provided written statement signed by the member and the provider that the member's pregnancy resulted from rape or incest and by professional judgement, the provider agrees with the woman's statement. <p>Section 2:</p> <ul style="list-style-type: none"> • The provider must provide a signed written statement indicating why, in the provider's professional judgement, the life of a woman would be endangered if the fetus were carried to term 					
Prescriber (or Staff) / Pharmacy Signature**					Date
<p>** : 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.</p>					

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:		
TELEPHONE NUMBER		FAX NUMBER	DRUG		NDC #