Acentra HEALTH

Prior Authorization Vendor for ND Medicaid

Mifepristone
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 new prescription for mifepristone to meet specific clinical criteria for coverage which can be found at https://ndmedicaid.acentra.com/ndpdl/

Documentation required: Please ensure written statement required by criteria is attached along with the request (see section 1 and 2 below).

Member Name	Member Date of Birth	Member Medicaid ID Number	
Prescriber Name	Prescriber NPI		
Address	Telephone Number	Fax Number	
Diagnosis for the Request:	City	State	Zip Code
Requested Drug, Strength, and Directions:		**Dosage Form (e.g., tablet):**	

Qualifications for Coverage:

1. Is the member terminating a pregnancy before 70 days of gestation? □ YES □ NO
2. Is the member resulting from an act of rape or incest? □ YES □ NO
   - o *If yes, please attach written statements as outlined in **section 1** below*
3. Does the member suffer from a physical disorder, injury, or illness that would place the member in danger of death unless abortion is performed? □ YES □ NO
   - o *If yes, please attach a written statement as outlined in **section 2** below*

Section 1:

- 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 member's statement.

Section 2:

- The provider must provide a signed written statement indicating why, in the provider's professional judgement, the life of a member would be endangered if the fetus were carried to term

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.*