Acentra HEALTH

Primary Hyperoxaluria Type 1 (PH1) 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 prescription for non-preferred medications to meet specific criteria for coverage found at https://ndmedicaid.acentra.com/ndpdl/

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

Qualifications for Coverage:

1. The member's diagnosis has been confirmed by the following (select all that apply):
   - ☐ Mutation in the alanine: glyoxylate aminotransferase (AGXT) gene confirmed by genetic testing
   - ☐ Liver enzyme analysis confirming absent or significant deficiency in alanine: glyoxylate aminotransferase (AGT) activity
2. The member has received a liver transplant ☐ YES ☐ NO
3. Member's baseline and current urinary oxalate excretion before and after pyridoxine trial:
   - ☐ Baseline: _____ Date: _____
   - ☐ Current: _____ Date: _____
4. Please ensure documentation of one of the following is submitted along with the request:
   - ☐ Urinary oxalate excretion
   - ☐ Urinary oxalate: creatinine ratio
   - ☐ Estimated glomerular filtration rate (eGFR)

Renewal Requests only: assessment of the member's clinical benefit since starting the requested agent

Please ensure clinical notes are submitted along with the request, including the member's change from baseline of one of the following:

- ☐ Signs and symptoms
- ☐ Urinary oxalate excretion
- ☐ Elevated urinary oxalate: creatinine ratio

☐ *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.*