Prior Authorization Vendor for ND Medicaid

Spinal Muscular Atrophy Prior Authorization Form

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

ND Medicaid requires that patients receiving a prescription for treatments of spinal muscular atrophy must meet the agent criteria located on the Preferred Drug List (PDL), located on the North Dakota Department of Human Services Prior Authorization website at http://www.hidesigns.com/ndmedicaid. Please fill out this request form in its entirety, answer all questions relevant to the requested product, and attach any required documentation to this request form.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Prescriber NPI		
Billing Facility NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Billing Facility NPI	ICD-10 Code:		
Requested Drug and Dose:			
Diagnosis for this request: ☐ **SMA Type 1** ☐ **SMA Type 2** ☐ **SMA Type 3**			
Patient's weight:	**Baseline motor ability score:**	**Age at SMA symptom onset:**	

Question		
Does the patient have respiratory insufficiency?	☐ **YES**	☐ **NO**
Does the patient require gastric feeding tubes for the majority of feeds?	☐ **YES**	☐ **NO**
Does the patient have severe contractures or severe scoliosis?	☐ **YES**	☐ **NO**
Does the patient have wasting or cachexia?	☐ **YES**	☐ **NO**
Does the patient experience issues with ambulating?	☐ **YES**	☐ **NO**
Has the patient reached full gestational age?	☐ **YES**	☐ **NO**
Has all required documentation been attached to the request (e.g. genetic testing, antibody titers, motor ability scores)?	☐ **YES**	☐ **NO**

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 patient'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.*