Acentra HEALTH

Prior Authorization Vendor for ND Medicaid

Sedative/Hypnotic
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 sedative/hypnotic must meet specific clinical criteria for coverage which can be found at https://ndmedicaid.acentra.com/ndpdl/

- **Documentation required:** see section B below for sighted members

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

SECTION A: Insomnia

1. Have other conditions causing sleep issues been ruled out? ☐ YES ☐ NO
2. Is the member's insomnia characterized by difficulty with sleep maintenance? ☐ YES ☐ NO
3. Is the member's insomnia characterized by difficulty with sleep initiation? ☐ YES ☐ NO
4. *For benzodiazepine requests only:* Does the member require dose tapering? ☐ YES ☐ NO

SECTION B: Non-24 Hour Sleep-Wake Disorder

1. Is the member blind in both eyes? ☐ YES ☐ NO
   a. *If no,* please ensure the following **documentation** is attached to the request: member's diagnosis been confirmed by self-reported sleep diaries or actigraphy for at least 14 days demonstrating a gradual drift (typically later) in rest-activity patterns not better explained by sleep hygiene, substance, or medication use, or other neurological or mental disorders

Clinical justification explaining why the member is unable to use the preferred agents (only applicable if criteria requires):

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

☐ *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.*