Acentra HEALTH

Prior Authorization Vendor for ND Medicaid

Tardive Dyskinesia Agents
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 Austedo, Ingrezza, or tetrabenazine must meet specific criteria for coverage found at https://ndmedicaid.acentra.com/ndpdl/

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

Qualifications for coverage:

1. Does the member have a history of treatment with a dopamine receptor blocking agent (DRBA)? ☐ YES ☐ NO
2. Current AIMS score:
   - ☐ Total AIMS score of items 1-7: _____
   - ☐ AIMS score on item 8: _____
   - ☐ AIMS score on item 9: _____

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

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.*