health information designs

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 patients receiving a new prescription for Austedo, Ingrezza, or tetrabenazine must meet the following criteria:

Category Criteria

- The patient must be 18 years of age or older.
- The prescription must be written by/in consultation with a specialist (neurologist or psychiatrist).
- The patient must have a diagnosis of tardive dyskinesia, including the following:
  - Involuntary athetoid or choreiform movements
  - History of treatment with dopamine receptor blocking agent (DRBA)
  - Symptom duration lasting longer than 4-8 weeks
- The patient must not be taking monoamine oxidase inhibitor (MAOI)
- The patient is not pregnant or breastfeeding

Product Specific Criteria: * Austedo/tetrabenazine:**

- The patient must have a diagnosis of Huntington's disease or Tardive Dyskinesia.
- The patient must not have hepatic impairment

Part I: TO BE COMPLETED BY PRESCRIBER/PRESCRIBER'S OFFICE

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		
List all failed medications (drug name, date of trial, reason for failure):			
Qualifications for coverage:			
Does the patient's diagnosis include athetoid or choreiform movements?		□ YES □ NO	
Has the symptom duration lasted longer than 4-8 weeks?		□ YES □ NO	
Is the patient pregnant or breastfeeding?		□ 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.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #