DUR Board Meeting
December 2, 2015
Pioneer Room
State Capitol

North Dakota Medicaid
DUR Board Meeting Agenda
Pioneer Room
State Capitol
600 East Boulevard Avenue
Bismarck, ND
December 2, 2015
1pm

1. Administrative items
    - Travel vouchers

2. Old business
    - Review and approval of minutes of 09/15 meeting minutes
    - Budget update
    - Review top 15 therapeutic categories/top 25 drugs
    - Second review of Marinol
    - Second review of skin pigment products
    - Second review of inhaled corticosteroid/LABA combination products
    - Second review of Movantik
    - Second review of medications used to treat irritable bowel syndrome
    - Second review of medications used to treat ulcerative colitis
    - Second review of SGLT2 products
    - Second review of immediate release oxycodone
    - Second review of inhaled anti-infectives for cystic fibrosis
    - IR narcotics used in conjunction with IR narcotic combinations update
    - Gabapentin update
    - Annual review of prior authorization forms and criteria/prior authorization update

3. New business
    - Review of cytokine modulators
    - Review of insulin
    - Review of steroid inhalers
    - Review of digestive enzymes
    - Review of nasal steroids
    - Review of otic anti-infectives
    - Review of ulcer anti-infectives
    - Criteria recommendations
    - Upcoming meeting date/agenda

4. Adjourn

Please remember to silence all cellular phones during the meeting.

Drug Utilization Review (DUR) Meeting Minutes
September 2, 2015

Members Present: Tanya Schmidt, Laura Schield, Katie Kram, Wendy Brown, Michael Quast, Russ Sobotta, Peter Woodrow, Andrea Honeyman, Jeffrey Hostetter, Carlotta McCleary

Members Absent: James Carlson, Steve Irsfeld, Michael Booth, Gary Betting

Medicaid Pharmacy Department: Brendan Joyce, Alexi Murphy

W. Brown called the meeting to order at 1:00 p.m. Chair W. Brown asked for a motion to approve the minutes of the June meeting. T. Schmidt moved that the minutes be approved, and L. Schield seconded the motion. Chair W. Brown called for a voice vote to approve the minutes. The motion passed with no audible dissent.

DUR Board new member:
B. Joyce introduced Andrea Honeyman as the most recent pharmacist appointed to the DUR Board.

Second reviews
A motion and second were made at the June meeting to place PCSK9 inhibitors, injectable anticoagulants, Akynzeo, Nuvessa, and Cholbam on prior authorization. The topics were brought up for a second review. Corinne Copeland and Ronda Copher, representing Eisai spoke regarding Akynzeo. The motion to place these medications on prior authorization passed with no audible dissent.

Update on medications > $3,000
A. Murphy gave an update on medications that have been added to the > $3,000 prior authorization list. Cholbam, Natpara, and Orkambi are the most recent additions.

Sanford Health Plan update
Michael Crandell, Else Umbreti and Bill Ladwig gave an update on Medicaid expansion in North Dakota. Michael Crandell is the Chief Medical Officer of Sanford Health Plan.

Prior authorization update on current drugs/classes
A. Murphy gave an update on drugs that have been added to prior authorization. Technivie, Tudorza, Arcapta, Daklinza, Brovana, Vimizim, and Promacta have all been added to prior authorization. Also, hepatitis C medications will soon be considered under the supplemental rebate program. A review of the forms and criteria for these agents will be on the agenda for December.

Movantik review
B. Joyce reviewed Movantik with the Board. B. Haas, representing AstraZeneca, spoke. A motion was made by M. Quast to place Movantik on prior authorization. J. Hostetter seconded the motion. This topic will be reviewed at the next meeting.

Marinol review
B. Joyce reviewed Marinol with the Board. A motion was made by L. Schield to place Marinol on prior authorization. The motion was seconded by K. Kram. There was no public comment. This topic will be reviewed at the next meeting.

Skin pigment products review
B. Joyce reviewed skin pigment products with the Board. A motion was made by M. Quast to allow the department to manage the class of skin pigment products through prior authorization.

The motion was seconded by J. Hostetter. There was no public comment. This topic will be reviewed at the next meeting.

Inhaled corticosteroid/long-acting beta-2 adrenergic agonist combination products review
A. Murphy reviewed inhaled corticosteroid/LABA combination products with the Board. Recommendations include quantity limits allowing for 2 inhalers of albuterol per 2 months, MTM management for asthma, and prior authorization for appropriate utilization. J. Hostetter made a motion to place inhaled corticosteroids/LABA combination products on prior authorization. P. Woodrow seconded the motion. There was no public comment .This topic will be reviewed at the next meeting.

IBS medications review
B. Joyce reviewed IBS medications with the Board. There was no public comment. L. Schield made a motion to allow the department to manage the class through prior authorization. K. Kram seconded the motion. This topic will be reviewed at the next meeting.

Ulcerative colitis medications review
B. Joyce reviewed ulcerative colitis medications with the Board. There was no public comment. J. Hostetter made a motion to allow the department to manage the class through prior authorization. L. Schield seconded the motion. This topic will be reviewed at the next meeting.

SGLT2 inhibitors review
B. Joyce reviewed SGLT2 medications with the Board. B. Haas, representing AstraZeneca, spoke on behalf of Farxiga. J. Stoffel, representing Janssen, spoke on behalf of Invokana. T. Schmidt made a motion to allow the department to manage the class through prior authorization. J. Hostetter seconded the motion. This topic will be reviewed at the next meeting.

Immediate release oxycodone review
B. Joyce reviewed immediate release oxycodone utilization with the Board. The department would like guidance on the appropriate use of higher dosages of oxycodone immediate release without evidence of a long-acting agent. M. Quast made a motion to place high dose immediate release oxycodone on prior authorization. T. Schmidt seconded the motion. This topic will be reviewed at the next meeting.

Immediate release narcotics in conjunction with immediate release narcotic combinations review
B. Joyce reviewed narcotics in conjunction with immediate release narcotic combination products. The committee recommended drug-drug edits as well as prescriber education.

Inhaled anti-infectives for cystic fibrosis review
B. Joyce reviewed anti-infectives for cystic fibrosis with the Board. There was no public comment. J. Hostetter made a motion to allow the department to manage the class through prior authorization. T. Schmidt seconded the motion. This topic will be reviewed at the next meeting.

Leukotriene modifiers review
B. Joyce reviewed leukotriene modifiers with the Board. There was no public comment. J. Hostetter made a motion to allow the department to manage the class through prior authorization. K. Kram seconded the motion. This topic will be reviewed at the next meeting.

Gabapentin update
A. Murphy reviewed gabapentin data and quantity limit suggestions. The department will send a letter/survey to prescribers of gabapentin to let them know of any changes.

Criteria recommendations
The recommended RDUR criteria enclosed in the packet were developed from product information provided by the manufacturers and are usually consistent with new indications, new drugs added, new warnings, etc. These proposed criteria will be added to the current set of criteria and will be used in future DUR cycles. C. McCleary moved to approve the new criteria and K. Kram seconded the motion. Chair W. Brown called for a voice vote. The motion passed with no audible dissent.

The next DUR Board meeting will be held December 2 in Bismarck. L. Schield made a motion to adjourn the meeting. J. Hostetter seconded. The motion passed with no audible dissent. W. Brown adjourned the meeting.

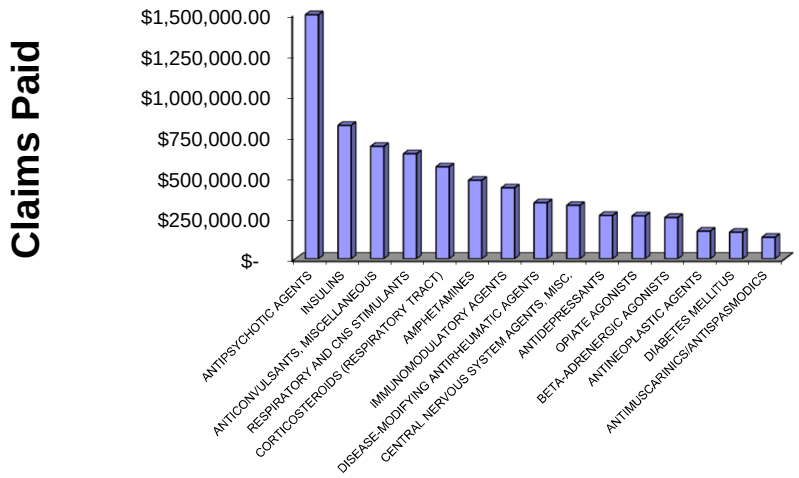
NORTH DAKOTA MEDICAID
Cost Management Analysis

TOP 15 THERAPEUTIC CLASSES BY TOTAL COST OF CLAIMS FROM 04/01/2015 - 06/30/2015

AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
ANTIPSYCHOTIC AGENTS	6,017	$ 1,494,454.82	$ 248.37	4.16%
INSULINS	1,745	$ 818,762.22	$ 469.20	1.21%
ANTICONVULSANTS, MISCELLANEOUS	8,338	$ 689,790.41	$ 82.73	5.77%
RESPIRATORY AND CNS STIMULANTS	4,948	$ 644,377.75	$ 130.23	3.42%
CORTICOSTEROIDS (RESPIRATORY TRACT)	2,082	$ 564,444.28	$ 271.11	1.44%
AMPHETAMINES	3,866	$ 482,031.00	$ 124.68	2.67%
IMMUNOMODULATORY AGENTS	73	$ 435,509.15	$ 5,965.88	0.05%
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	116	$ 343,993.74	$ 2,965.46	0.08%
CENTRAL NERVOUS SYSTEM AGENTS, MISC.	1,547	$ 328,075.95	$ 212.07	1.07%
ANTIDEPRESSANTS	14,015	$ 265,952.31	$ 18.98	9.69%
OPIATE AGONISTS	8,880	$ 263,345.09	$ 29.66	6.14%
BETA-ADRENERGIC AGONISTS	4,048	$ 253,542.23	$ 62.63	2.80%
ANTINEOPLASTIC AGENTS	353	$ 170,146.90	$ 482.00	0.24%
DIABETES MELLITUS	1,083	$ 163,241.15	$ 150.73	0.75%
ANTIMUSCARINICS/ANTISPASMODICS	906	$ 132,189.00	$ 145.90	0.63%
Total Top 15	58,017	$ 7,049,856.00	$ 121.51	40.12%

Total Rx Claims From 04/01/2015 - 06/30/2015	144,592

Top 15 Therapeutic Classes
Based on Total Cost of Claims

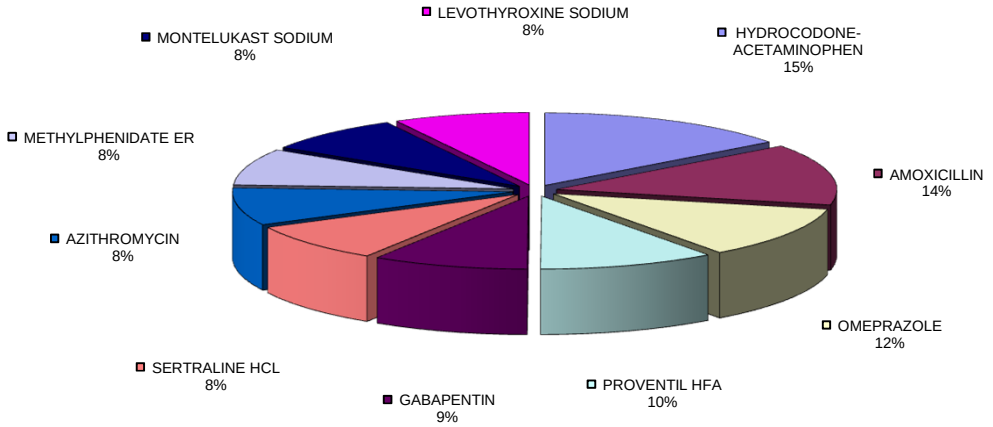


TOP 25 DRUGS BASED ON NUMBER OF CLAIMS FROM 04/01/2015 - 06/30/2015

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
HYDROCODONE-ACETAMINOPHEN	OPIATE AGONISTS	3,596	$ 73,507.71	$ 20.44	2.49%
AMOXICILLIN	PENICILLINS	3,318	$ 34,763.25	$ 10.48	2.29%
OMEPRAZOLE	PROTON-PUMP INHIBITORS	2,790	$ 30,138.62	$ 10.80	1.93%
PROVENTIL HFA	BETA-ADRENERGIC AGONISTS	2,468	$ 177,093.64	$ 71.76	1.71%
GABAPENTIN	ANTICONVULSANTS, MISCELLANEOUS	2,182	$ 50,342.83	$ 23.07	1.51%
SERTRALINE HCL	ANTIDEPRESSANTS	2,060	$ 19,642.94	$ 9.54	1.42%
AZITHROMYCIN	MACROLIDES	2,027	$ 36,707.54	$ 18.11	1.40%
METHYLPHENIDATE ER	RESPIRATORY AND CNS STIMULANTS	1,981	$ 328,262.35	$ 165.71	1.37%
MONTELUKAST SODIUM	LEUKOTRIENE MODIFIERS	1,980	$ 40,769.27	$ 20.59	1.37%
LEVOTHYROXINE SODIUM	THYROID AGENTS	1,909	$ 32,484.57	$ 17.02	1.32%
FLUOXETINE HCL	ANTIDEPRESSANTS	1,857	$ 12,285.43	$ 6.62	1.28%
TRAZODONE HCL	ANTIDEPRESSANTS	1,783	$ 12,715.59	$ 7.13	1.23%
LISINOPRIL	ANGIOTENSIN-CONVERTING ENZYME INHIBITORS	1,768	$ 12,741.40	$ 7.21	1.22%
OXYCODONE-ACETAMINOPHEN	OPIATE AGONISTS	1,464	$ 47,501.38	$ 32.45	1.01%
CLONIDINE HCL	CENTRAL ALPHA-AGONISTS	1,440	$ 11,311.25	$ 7.86	1.00%
VYVANSE	AMPHETAMINES	1,437	$ 263,283.32	$ 183.22	0.99%
AMOX TR-POTASSIUM CLAVULANATE	PENICILLINS	1,430	$ 36,552.88	$ 25.56	0.99%
TRAMADOL HCL	OPIATE AGONISTS	1,368	$ 11,332.80	$ 8.28	0.95%
BUPROPION XL	ANTIDEPRESSANTS	1,357	$ 30,137.80	$ 22.21	0.94%
METFORMIN HCL	BIGUANIDES	1,325	$ 10,789.33	$ 8.14	0.92%
RISPERIDONE	ANTIPSYCHOTIC AGENTS	1,324	$ 16,619.59	$ 12.55	0.92%
DEXTROAMPHETAMINE-AMPHET ER	AMPHETAMINES	1,319	$ 140,105.35	$ 106.22	0.91%
ATORVASTATIN CALCIUM	HMG-COA REDUCTASE INHIBITORS	1,315	$ 13,646.96	$ 10.38	0.91%
CLONAZEPAM	BENZODIAZEPINES (ANTICONVULSANTS)	1,297	$ 9,504.92	$ 7.33	0.90%
QUETIAPINE FUMARATE	ANTIPSYCHOTIC AGENTS	1,281	$ 20,680.68	$ 16.14	0.89%
TOTAL TOP 25		46,076	$ 1,472,921.40	$ 31.97	31.87%

Total Rx Claims From 04/01/2015 - 06/30/2015	144,592

Top 10 Drugs
Based on Number of Claims

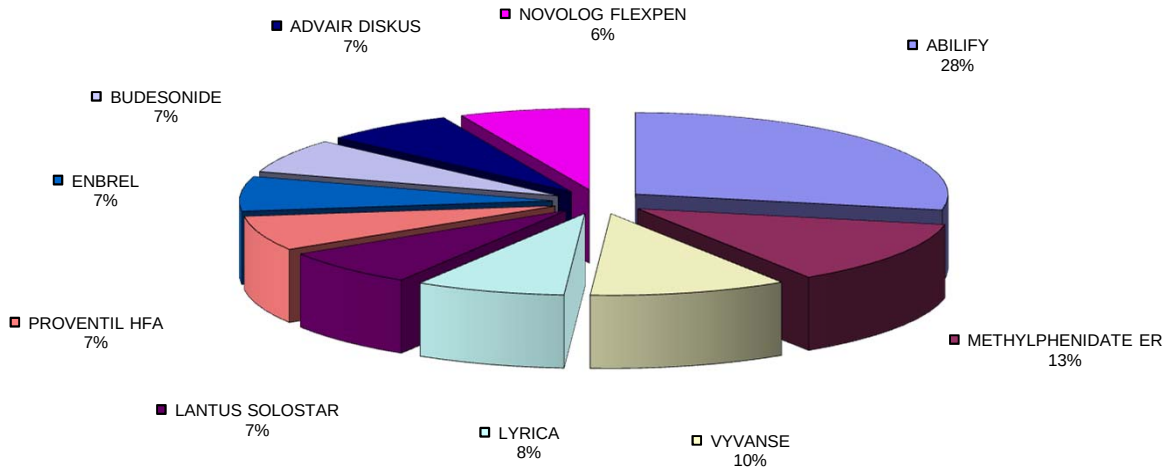


TOP 25 DRUGS BASED ON TOTAL CLAIMS COST FROM 04/01/2015 - 06/30/2015

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
ABILIFY	ANTIPSYCHOTIC AGENTS	883	$ 725,389.74	$ 821.51	0.61%
METHYLPHENIDATE ER	RESPIRATORY AND CNS STIMULANTS	1,981	$ 328,262.35	$ 165.71	1.37%
VYVANSE	AMPHETAMINES	1,437	$ 263,283.32	$ 183.22	0.99%
LYRICA	ANTICONVULSANTS, MISCELLANEOUS	605	$ 199,663.83	$ 330.02	0.42%
LANTUS SOLOSTAR	INSULINS	448	$ 188,019.39	$ 419.69	0.31%
PROVENTIL HFA	BETA-ADRENERGIC AGONISTS	2,468	$ 177,093.64	$ 71.76	1.71%
ENBREL	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	49	$ 176,949.40	$ 3,611.21	0.03%
BUDESONIDE	CORTICOSTEROIDS (EENT)	584	$ 174,590.76	$ 298.96	0.40%
ADVAIR DISKUS	CORTICOSTEROIDS (RESPIRATORY TRACT)	556	$ 173,070.01	$ 311.28	0.38%
NOVOLOG FLEXPEN	INSULINS	358	$ 173,044.21	$ 483.36	0.25%
STRATTERA	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	599	$ 169,223.71	$ 282.51	0.41%
LEVEMIR FLEXTOUCH	INSULINS	310	$ 157,053.89	$ 506.63	0.21%
FREESTYLE LITE STRIPS	DIABETES MELLITUS	961	$ 144,559.10	$ 150.43	0.66%
DEXTROAMPHETAMINE-AMPHET ER	AMPHETAMINES	1,319	$ 140,105.35	$ 106.22	0.91%
COPAXONE	IMMUNOMODULATORY AGENTS	22	$ 137,163.82	$ 6,234.72	0.02%
GUANFACINE HCL ER	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	815	$ 127,354.37	$ 156.26	0.56%
LATUDA	ANTIPSYCHOTIC AGENTS	156	$ 125,690.05	$ 805.71	0.11%
HELIXATE FS	HEMOSTATICS	5	$ 113,467.84	$ 22,693.57	0.00%
SEROQUEL XR	ANTIPSYCHOTIC AGENTS	233	$ 112,404.21	$ 482.42	0.16%
INVEGA SUSTENNA	ANTIPSYCHOTIC AGENTS	72	$ 111,763.94	$ 1,552.28	0.05%
ARIPIPRAZOLE	ANTIPSYCHOTIC AGENTS	273	$ 111,040.07	$ 406.74	0.19%
SPIRIVA	ANTIMUSCARINICS/ANTISPASMODICS	276	$ 87,674.41	$ 317.66	0.19%
INVEGA	ANTIPSYCHOTIC AGENTS	93	$ 84,948.78	$ 913.43	0.06%
VIMPAT	ANTICONVULSANTS, MISCELLANEOUS	150	$ 83,613.90	$ 557.43	0.10%
AUVI-Q	ALPHA- AND BETA-ADRENERGIC AGONISTS	181	$ 81,171.13	$ 448.46	0.13%
TOTAL TOP 25		14,834	$ 4,366,601.22	$ 294.36	10.26%

Total Rx Claims From 04/01/2015 - 06/30/2015	144,592

Top 10 Drugs
Based on Total Claims Cost



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Prior Authorization Vendor for ND Medicaid

Marinol
Prior Authorization

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 Marinol must meet the following criteria:

- *Patient must have diagnosis of anorexia associated with weight loss in patients with AIDS; or*
- *Diagnosis of nausea and vomiting associated with cancer chemotherapy*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

QUALIFICATIONS FOR COVERAGE:

Requested Drug and Dosage: □ **Marinol**	Diagnosis for this request:
Prescriber (or Staff) / Pharmacy Signature	Date

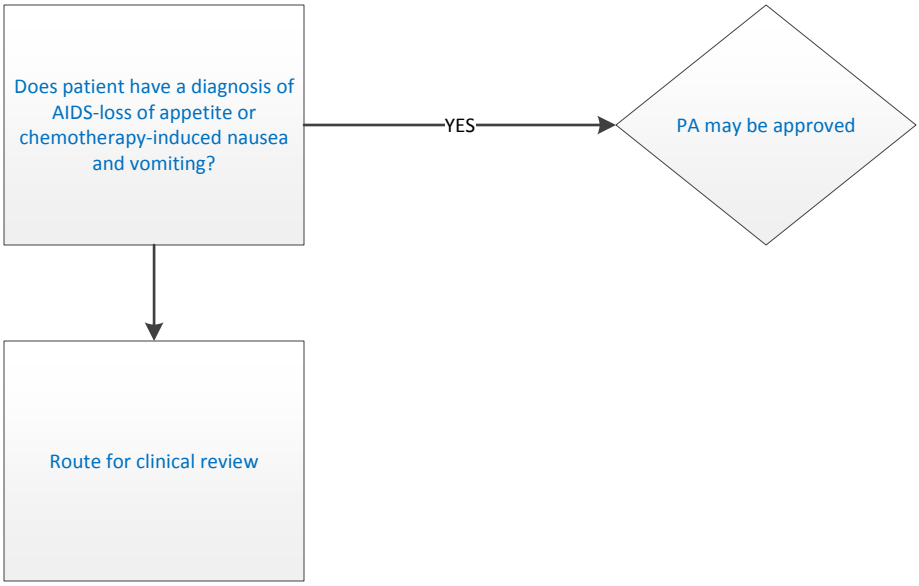
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Marinol Authorization Algorithm



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Prior Authorization Vendor for ND Medicaid

Inhaled Corticosteroid/Long-Acting Beta-2 Agonists Prior Authorization

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 these agents must meet the following criteria:

- *Patient must have a diagnosis of COPD or asthma.*
- *Requires step therapy. See inhaled corticosteroid/LABA criteria for more details.*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
QUALIFICATIONS FOR COVERAGE:			
Requested Drug and Dosage: □ **Advair 100-50** □ **Advair 250-50** □ **Advair 500-50** □ **Advair HFA 115-21** □ **Advair HFA 230-21** □ **Dulera 200-5** □ **Symbicort 80-4.5** □ **Symbicort 160-4.5**		Diagnosis for this request:	
Failed therapy (list all that apply)	Start Date	End Date	
Questions: 1. Is the patient enrolled in MTM? □ YES □ NO 2. Is an asthma specialist involved in patient's care? □ YES □ NO 3. Has the patient been reviewed for step-down therapy? □ YES □ NO			
Prescriber (or Staff) / Pharmacy Signature		Date	

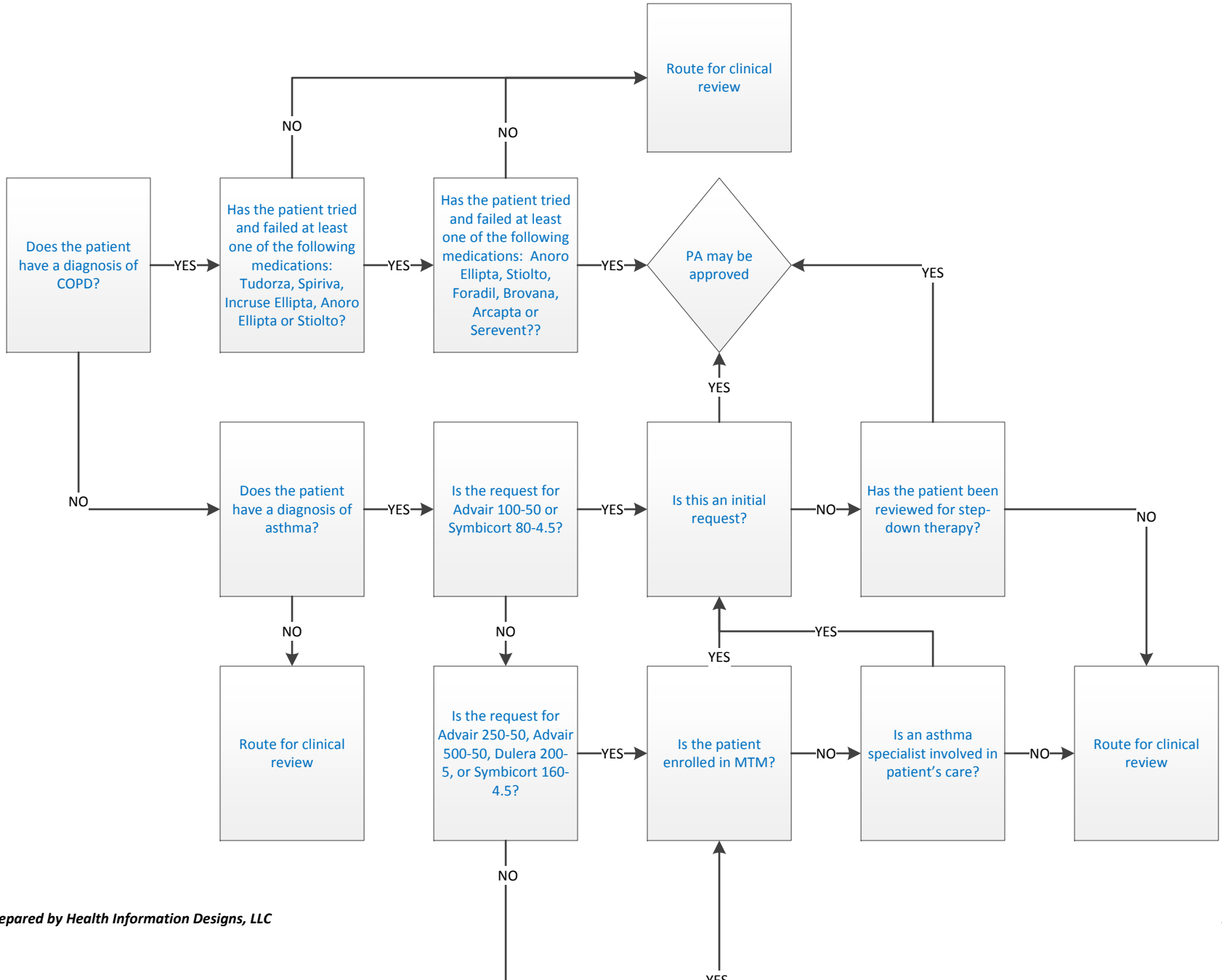
Part II: TO BE COMPLETED BY PHARMACY

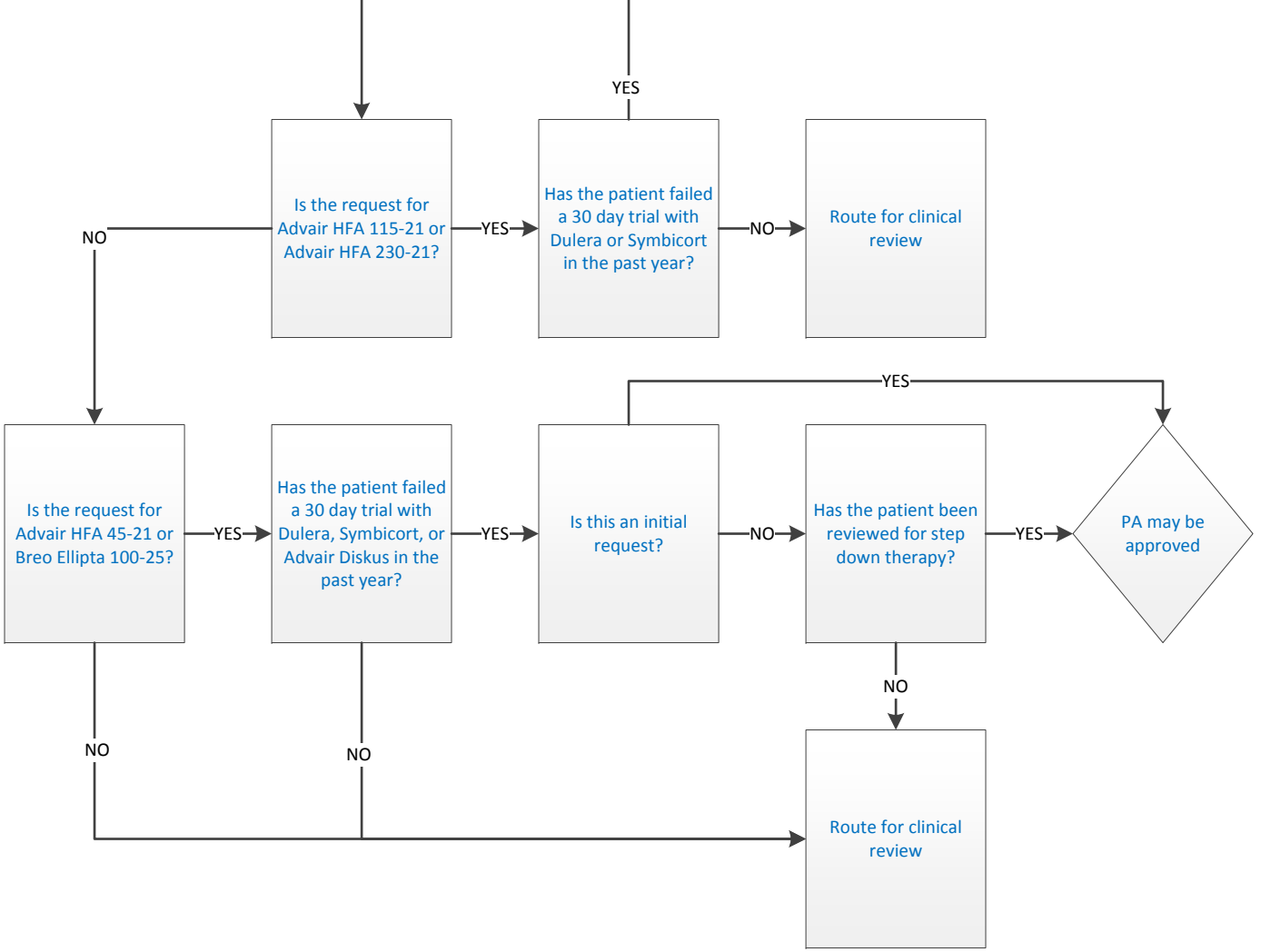
PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Inhaled Corticosteroid/LABA Authorization Algorithm




YES
Is the request for Advair HFA 115-21 or Advair HFA 230-21?
YES
Has the patient failed a 30 day trial with Dulera or Symbicort in the past year?
NO
Route for clinical review
NO
YES
Is the request for Advair HFA 45-21 or Breo Ellipta 100-25?
YES
Has the patient failed a 30 day trial with Dulera, Symbicort, or Advair Diskus in the past year?
YES
Is this an initial request?
NO
Has the patient been reviewed for step down therapy?
YES
PA may be approved
NO
NO
NO
Route for clinical review

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Prior Authorization Vendor for ND Medicaid

Medications Used to Treat IBS/OIC
Prior Authorization

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 medications used to treat IBS/OIC must meet the following criteria:

- *Patient must have diagnosis of chronic constipation, IBS with constipation, or opioid-induced constipation.*
- *Requires step therapy. See IBS/OIC criteria for more details.*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

QUALIFICATIONS FOR COVERAGE:	
Requested Drug and Dosage:	Diagnosis for this request: Is the patient unable to tolerate oral medications?
Failed therapy:	Start Date: End Date:
Prescriber (or Staff) / Pharmacy Signature	Date

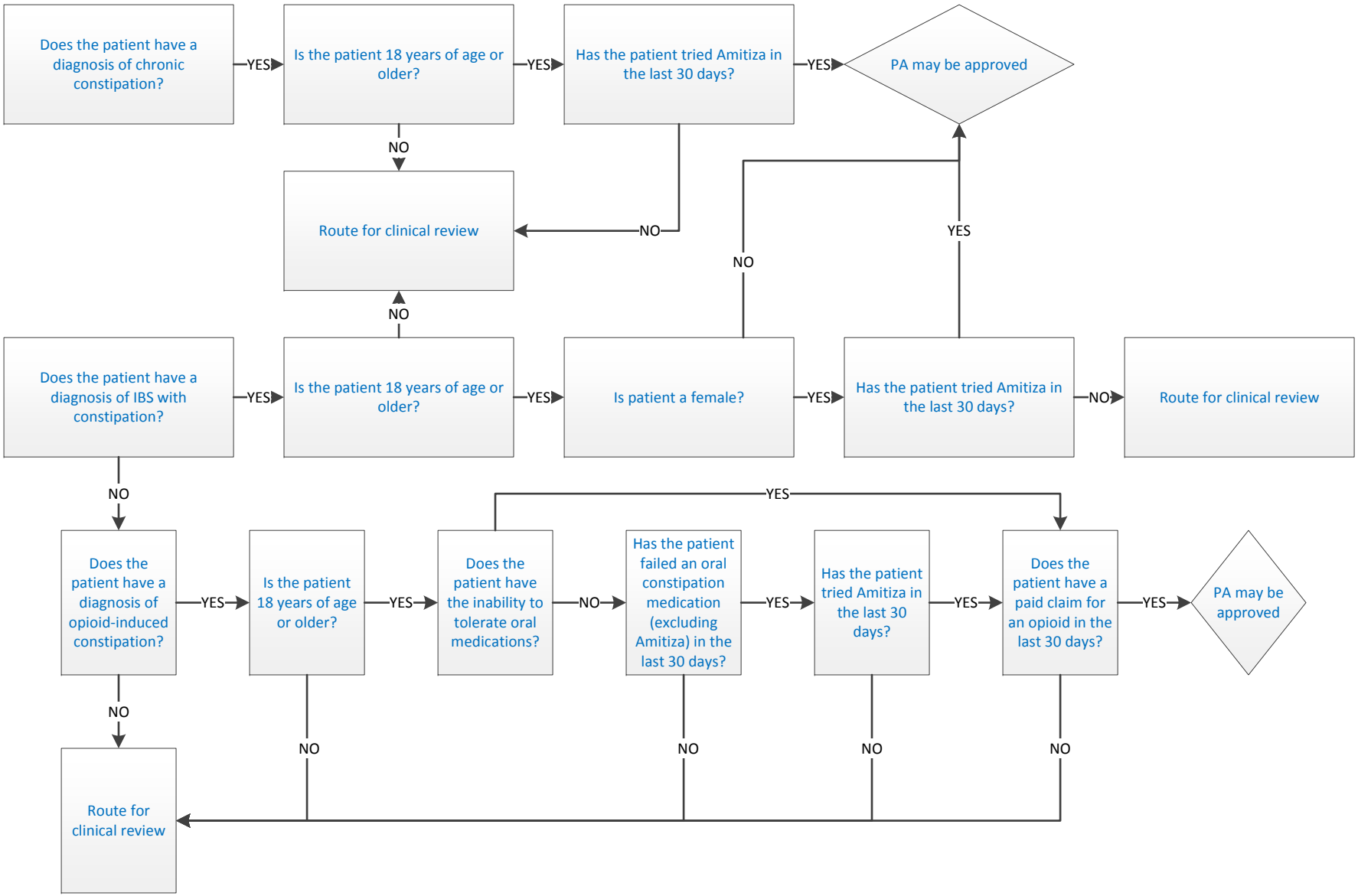
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Medications for IBS/OIC Authorization Algorithm



health information designs

Medications Used to Treat Ulcerative Colitis Prior Authorization

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 patients receiving a new prescription for Asacol HD, Dipentum, or Giazo must try and fail 30 days of Delzicol, Apriso, Pentasa, or Lialda.

- ***Asacol HD, Dipentum, and Giazo are FDA-approved to treat flares in patients with moderately active ulcerative colitis.***

Part I: TO BE COMPLETED BY PHYSICIAN

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:	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED THERAPY START DATE: END DATE:	DOSE: FREQUENCY:		
Prescriber (or Staff) / Pharmacy Signature		Date	

Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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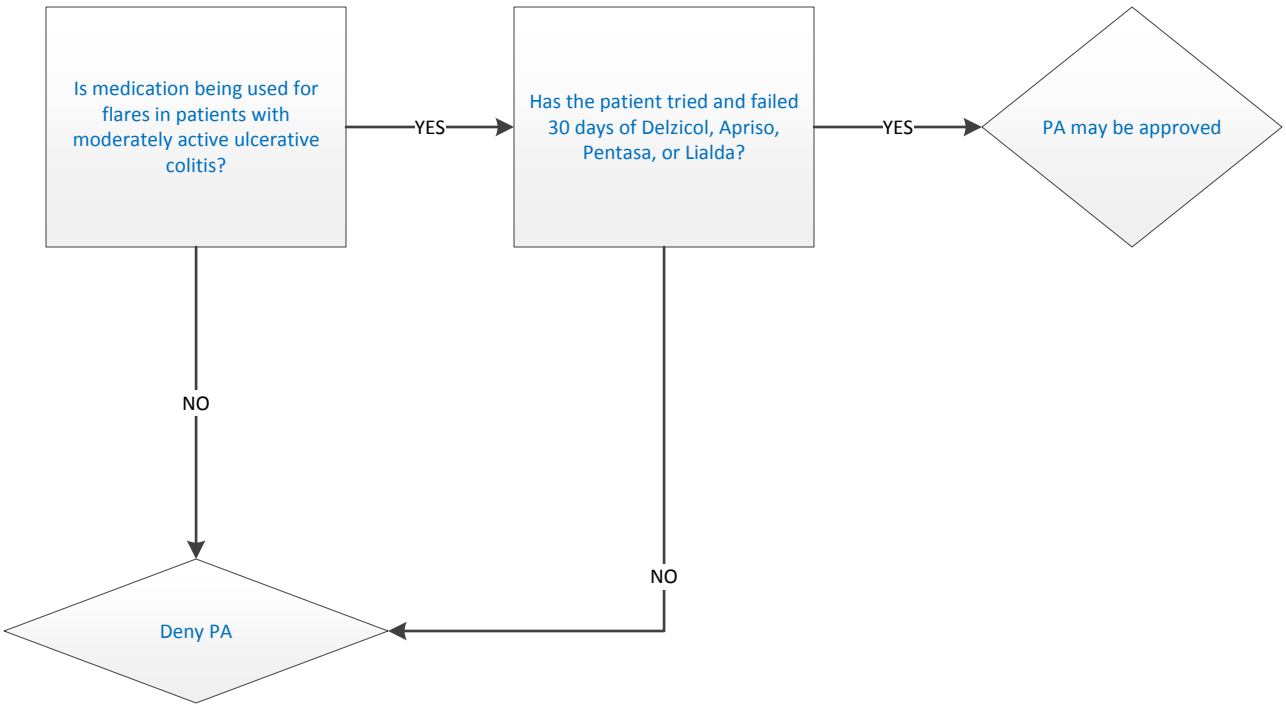
North Dakota Department of Human Services
Medications Used to Treat Ulcerative Colitis
Authorization Algorithm



health information designs

SGLT2 Inhibitors
Prior Authorization

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 patients receiving a new prescription for SGLT2 inhibitors must meet the following criteria:

- *Patient must have diagnosis of type II diabetes.*
- *Requires step therapy. See criteria for SGLT2 inhibitors for more information.*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

QUALIFICATIONS FOR COVERAGE:

Requested Drug and Dosage:		Diagnosis for this request:
Failed therapy:	Start Date:	End Date:
Prescriber (or Staff) / Pharmacy Signature:		Date:

Part II: TO BE COMPLETED BY PHARMACY

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

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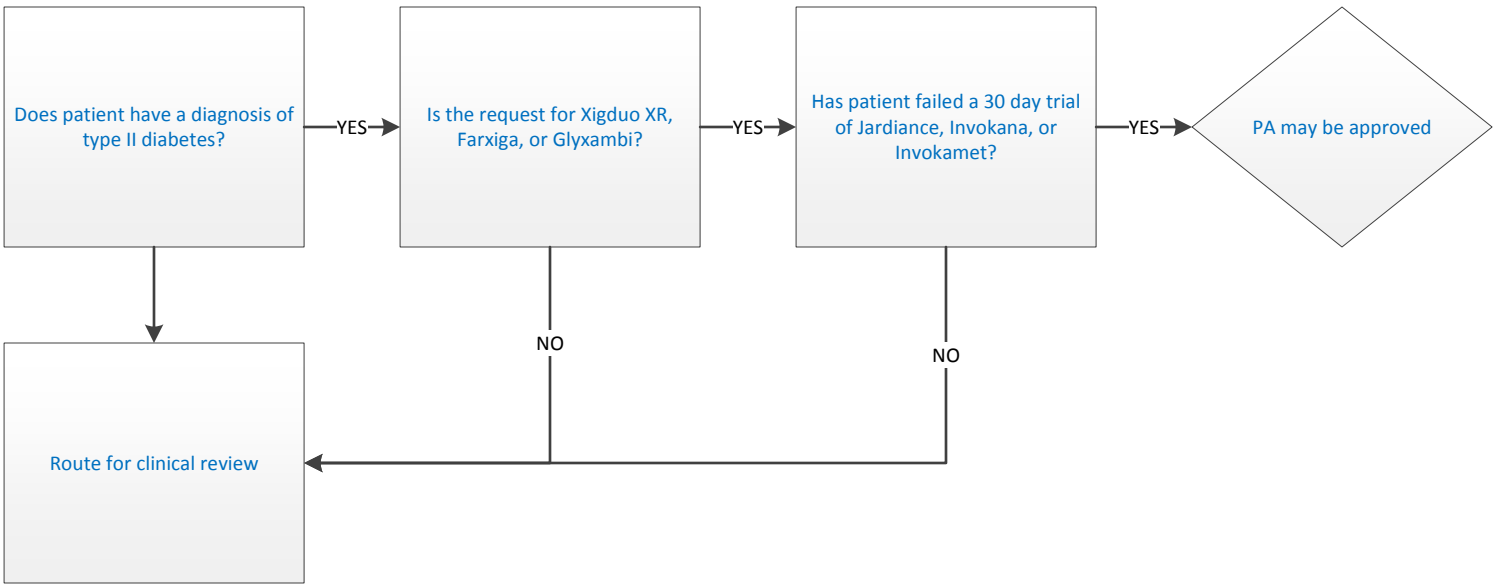
Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
SGLT2 Inhibitors Authorization Algorithm



NARCOTICS PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 a narcotic must meet the following criteria:

- **Documented failure of a 30-day trial of a generic narcotic.**
- **Requires step therapy. See narcotic criteria for more information.**

Part I: TO BE COMPLETED BY PHYSICIAN

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: **Diagnosis:** **Does the patient have cancer pain?**

Has patient required daily use of opioids for at least 90 days?

FAILED THERAPY	**START DATE**	**END DATE**	**DOSE**	**FREQUENCY**

Prescriber (or State) / Pharmacy Signature	Date

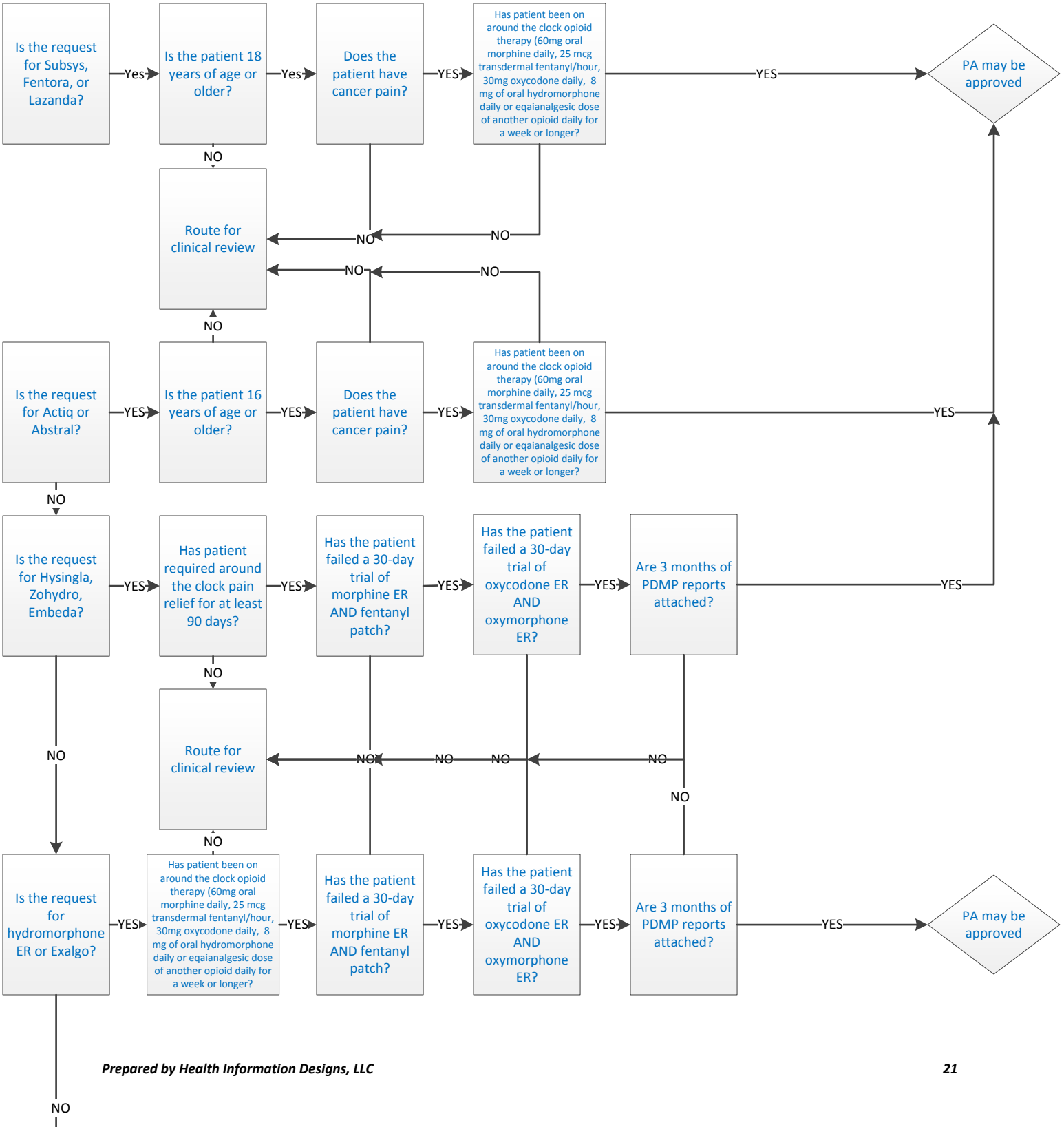
Part II: TO BE COMPLETED BY PHARMACY

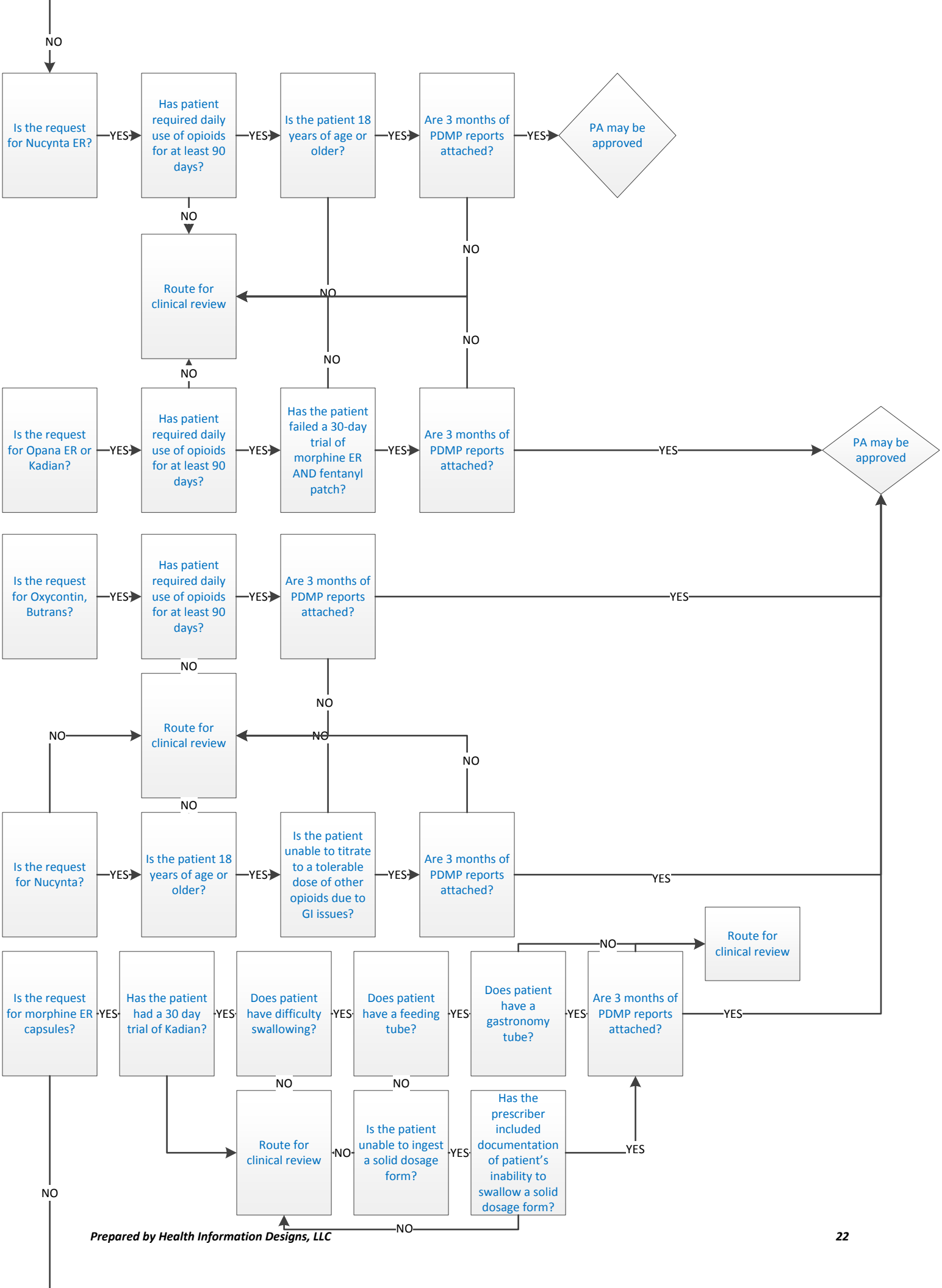
PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

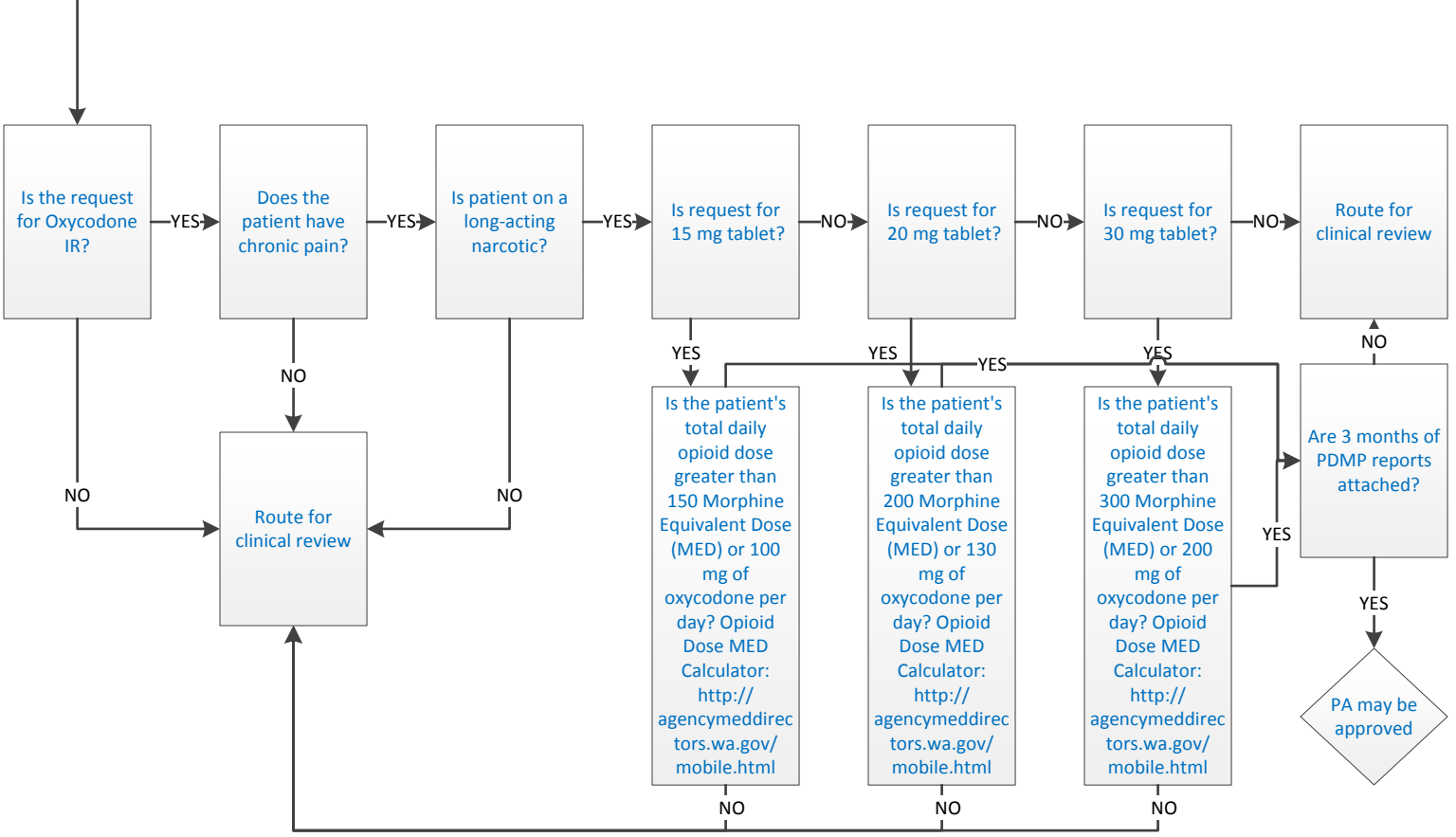
Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Narcotics Authorization Algorithm




NO
Is the request for Nucynta ER?
YES
Has patient required daily use of opioids for at least 90 days?
YES
Is the patient 18 years of age or older?
YES
Are 3 months of PDMP reports attached?
YES
PA may be approved
NO
Route for clinical review
NO
NO
NO
NO
Is the request for Opana ER or Kadian?
YES
Has patient required daily use of opioids for at least 90 days?
YES
Has the patient failed a 30-day trial of morphine ER AND fentanyl patch?
YES
Are 3 months of PDMP reports attached?
YES
PA may be approved
Is the request for Oxycontin, Butrans?
YES
Has patient required daily use of opioids for at least 90 days?
YES
Are 3 months of PDMP reports attached?
YES
NO
Route for clinical review
NO
NO
NO
NO
Is the request for Nucynta?
YES
Is the patient 18 years of age or older?
YES
Is the patient unable to titrate to a tolerable dose of other opioids due to GI issues?
YES
Are 3 months of PDMP reports attached?
YES
NO
Route for clinical review
Is the request for morphine ER capsules?
YES
Has the patient had a 30 day trial of Kadian?
YES
Does patient have difficulty swallowing?
YES
Does patient have a feeding tube?
YES
Does patient have a gastronomy tube?
YES
Are 3 months of PDMP reports attached?
YES
NO
NO
Route for clinical review
NO
Is the patient unable to ingest a solid dosage form?
YES
Has the prescriber included documentation of patient's inability to swallow a solid dosage form?
YES
NO
NO


Is the request for Oxycodone IR?
YES
Does the patient have chronic pain?
YES
Is patient on a long-acting narcotic?
YES
Is request for 15 mg tablet?
NO
Is request for 20 mg tablet?
NO
Is request for 30 mg tablet?
NO
Route for clinical review
NO
Route for clinical review
NO
NO
YES
Is the patient's total daily opioid dose greater than 150 Morphine Equivalent Dose (MED) or 100 mg of oxycodone per day? Opioid Dose MED Calculator: http://agencymeddirectors.wa.gov/mobile.html
YES
Is the patient's total daily opioid dose greater than 200 Morphine Equivalent Dose (MED) or 130 mg of oxycodone per day? Opioid Dose MED Calculator: http://agencymeddirectors.wa.gov/mobile.html
YES
Is the patient's total daily opioid dose greater than 300 Morphine Equivalent Dose (MED) or 200 mg of oxycodone per day? Opioid Dose MED Calculator: http://agencymeddirectors.wa.gov/mobile.html
YES
Are 3 months of PDMP reports attached?
NO
YES
PA may be approved
NO
NO
NO

health information designs

Prior Authorization Vendor for ND Medicaid

Inhaled Anti-Infectives for Cystic Fibrosis Prior Authorization

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 anti-infectives to treat cystic fibrosis must meet the following criteria:

- *Patient must have a diagnosis of Cystic Fibrosis*
- *Requires step therapy. See criteria for inhaled anti-infectives to treat cystic fibrosis for more information.*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

QUALIFICATIONS FOR COVERAGE:

Requested Drug and Dosage:	Diagnosis for this request:
Questions: 1. *Does the patient have a FEV1 less than 25% or greater than 75% predicted?* □*Yes* □*No* 2. *Does the patient have a FEV1 less than 40% or greater than 80% predicted?* □*Yes* □*No* 3. *Has the patient been colonized with Burkholderia cepacia?* □*Yes* □*No*	
Failed Therapy:	Start Date: End Date:
Prescriber (or Staff) / Pharmacy Signature	Date

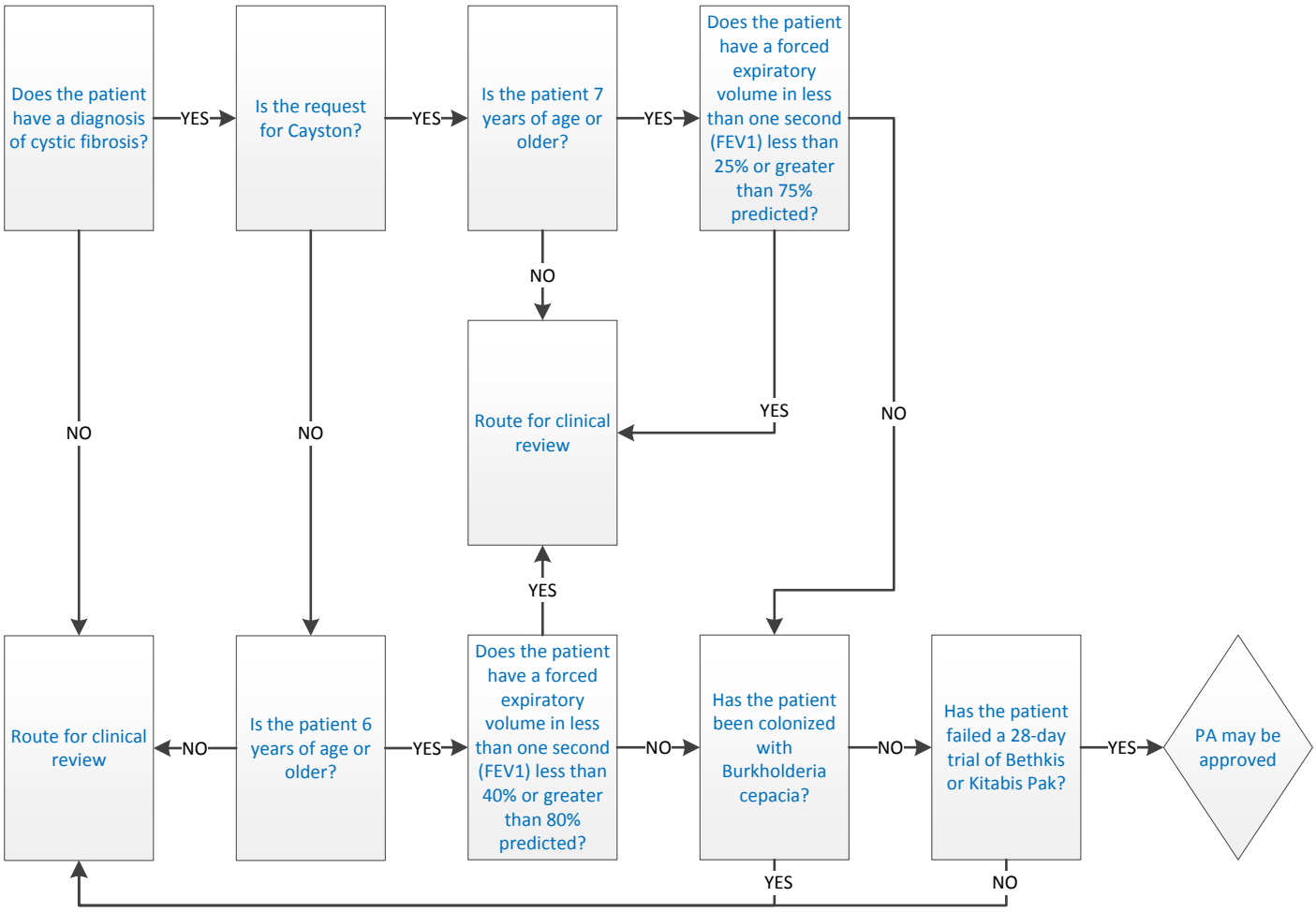
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Anti-Infectives for Cystic Fibrosis Authorization Algorithm



Leukotriene Modifiers
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 leukotriene modifiers must meet the following criteria:

- **Patient must have a confirmed diagnosis of asthma or allergic rhinitis.**
- **Requires step therapy. See leukotriene modifiers criteria for more details.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
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:			
Prescriber (or Staff) / Pharmacy Signature		Date	

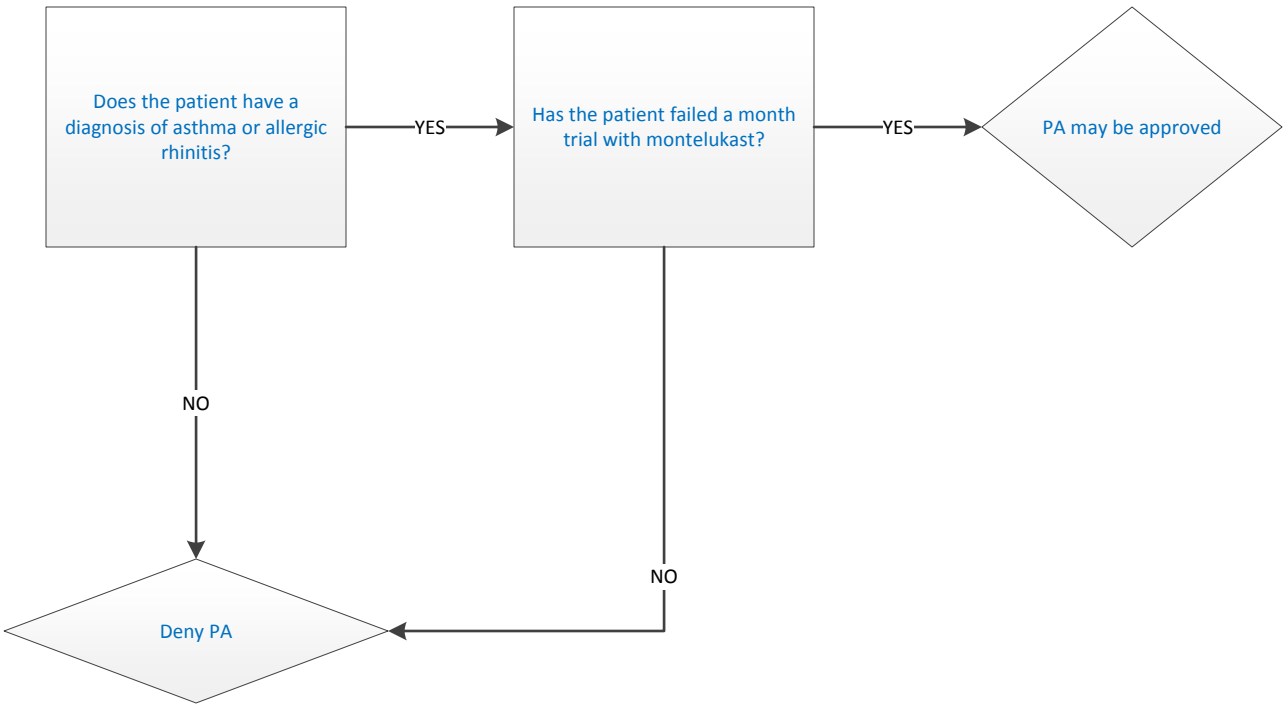
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Leukotriene Modifiers Authorization Algorithm



Gabapentin Dosing Recommendations

Fibromyalgia

- Study dose: Begin with 300 mg orally once daily at bedtime and titrate over 6 weeks to maximum of 2400 mg/day, given as 600 mg twice daily and 1200 mg at bedtime. Median dose was 1800 mg/day.

Postherpetic Neuralgia

Neurontin

- Usual dose: 300 mg orally single dose on day 1, followed by 600 mg on day 2 (divided twice daily), and 900 mg on day 3 (divided 3 times daily).
- Titration: As needed to 1800 mg/day in 3 divided doses; efficacious from 1800 to 3600 mg/day, but no additional benefit above 1800 mg/day.

Gralise

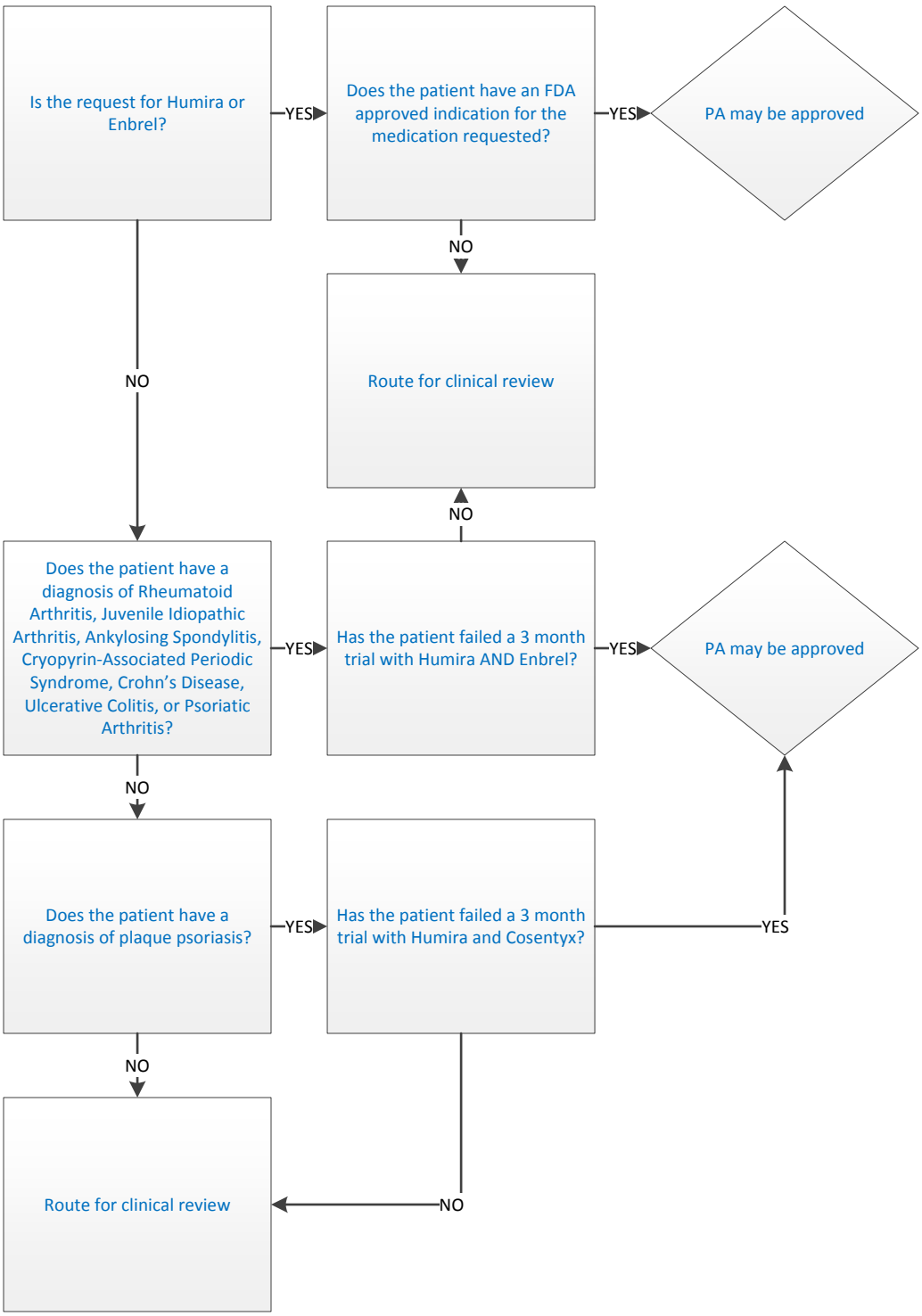
- Usual dose: 300 mg orally day 1, followed by 600 mg on day 2, 900 mg on days 3-6, 1200 mg on days 7-10, 1500 mg on days 11-14, and up to 1800 mg daily thereafter.

Postoperative Pain (Acute), Preemptive therapy

- Study dosing: Optimal dose and timing of administration not established; single oral doses of 300 to 1200 mg were administered 1 to 2 hours prior to surgery.

*Gradual dose reduction, discontinuation, or substitution over a minimum of 1 week is recommended.

North Dakota Department of Human Services
Cytokine Modulators Authorization Algorithm



PRODUCT DETAILS OF INSULINS

INDICATIONS AND USE:

Novolog (insulin aspart)

- Treatment of type 1 and 2 diabetes mellitus to improve glycemic control.

Tresiba (insulin degludec)

- To improve glycemic control in adults with diabetes mellitus.

Ryzodeg (insulin degludec/insulin aspart)

- To improve glycemic control in adults with diabetes mellitus.

Levemir (insulin detemir)

- To improve glycemic control in adults with diabetes mellitus.

Lantus/Toujeo (insulin glargine)

- To improve glycemic control in adults with type 1 and 2 diabetes mellitus.
- To improve glycemic control in children 6 years and older with type 1 diabetes mellitus (Lantus only)

Apidra (insulin glulisine)

- To improve glycemic control in adults and children with diabetes mellitus.

Humulin N (insulin isophane)

- Treatment of type 1 and type 2 diabetes to improve glycemic control.

Humulin 70/30/Novolin 70/30 (insulin isophane/insulin regular)

- Treatment of type 1 and type 2 diabetes to improve glycemic control.

Humalog (insulin lispro)

- Treatment of patients with diabetes mellitus to improve glycemic control.

Humulin R/Novolin R/Afrezza (insulin regular)

- As an adjunct to diet and exercise to improve glycemic control in adults and children with type 1 and type 2 diabetes mellitus.

ADMINISTRATION:

Novolog (insulin aspart)

- 0.2 to 0.6 units/kg/day in divided doses.

Tresiba (insulin degludec)

- Type: 1/3 to 1/2 of the total daily insulin dose. The remainder of the total daily insulin dose should be administered as a short-acting insulin divided between each daily meal.
- Type 2: The recommended starting dose is 10 units once daily.

Ryzodeg (insulin degludec/insulin aspart)

- Type: 1/3 to 1/2 of the total daily insulin dose. The remainder of the total daily insulin dose should be administered as a short- or rapid-acting insulin divided between each daily meal.
- Type 2: The recommended starting dose is 10 units once daily.

Levemir (insulin detemir)

- Type 1: Approximately 1/2 of the total daily insulin requirements. Rapid- or short-acting, premeal insulin should be used to satisfy the remainder of the daily insulin requirements.
- Type 2: 10 units (0.1 to 0.2 units/kg) once daily in the evening or divided into a twice-daily regimen in patients inadequately controlled on oral antidiabetic drugs or a glucagonlike peptide 1 (GLP-1) receptor antagonist.

Lantus/Toujeo (insulin glargine)

- Type 1: Approximately 1/3 to 1/2 of the total daily insulin requirements. A rapid-acting or short-acting insulin should also be used to complete the balance (approximately 2/3 to 1/2) of the daily insulin requirements.
- Type 2: 0.2 units/kg once daily. For Lantus, up to 10 units/day initially is recommended.

Apidra (insulin glulisine)

- 0.5 to 1 unit/kg/day administered 15 minutes before a meal or within 20 minutes of starting a meal.

Humulin N (insulin isophane)

- 0.5 to 1 unit/kg/day in 2 divided doses.

Humulin 70/30/Novolin 70/30 (insulin isophane/insulin regular)

- 0.5 to 1 unit/kg/day in 2 divided doses.

Humalog (insulin lispro)

- 0.5 to 1 unit/kg/day.

Humulin R/Novolin R/Afrezza (insulin regular)

- 0.5 to 1 units/kg/day divided into 3 or more subcutaneous doses. (initial dose 0.2 to 0.4 units/kg/day divided into 3 or more subcutaneous doses.

WARNINGS AND PRECAUTIONS:

- Hypoglycemia
- Hyperglycemia, diabetic ketoacidosis, and hyperosmolar hyperglycemic nonketotic syndrome
- Hypokalemia
- Antibody production
- Lipodystrophy

- Insulin initiation and glucose control intensification
- Weight gain
- Peripheral edema
- Hypersensitivity reactions

UTILIZATION

ND Medicaid Insulin Utilization		
08/25/14 - 08/24/15		
Label Name	**Rx Num**	**Total Reimb Amt**
APIDRA 100 UNITS/ML VIAL	33	$17,733.44
APIDRA SOLOSTAR 100 UNITS/ML	10	$1,699.68
HUMALOG 100 UNITS/ML CARTRIDGE	38	$18,610.50
HUMALOG 100 UNITS/ML KWIKPEN	455	$189,917.91
HUMALOG 100 UNITS/ML VIAL	233	$133,861.47
HUMALOG MIX 50-50 VIAL	1	$418.16
HUMALOG MIX 75-25 KWIKPEN	17	$18,902.10
HUMULIN 70/30 KWIKPEN	33	$14,694.51
HUMULIN 70-30 PEN	1	$316.64
HUMULIN 70-30 VIAL	34	$15,574.74
HUMULIN N 100 UNITS/ML KWIKPEN	32	$12,012.42
HUMULIN N 100 UNITS/ML PEN	3	$949.92
HUMULIN N 100 UNITS/ML VIAL	31	$4,543.01
HUMULIN R 100 UNITS/ML VIAL	33	$4,967.55
HUMULIN R 500 UNITS/ML VIAL	78	$94,331.10
LANTUS 100 UNITS/ML VIAL	566	$267,965.90
LANTUS SOLOSTAR 100 UNITS/ML	1795	$735,252.73
LEVEMIR 100 UNITS/ML VIAL	223	$101,213.37
LEVEMIR FLEXPEN 100 UNITS/ML	134	$57,695.43
LEVEMIR FLEXTOUCH 100 UNITS/ML	1001	$496,048.69
NOVOLOG 100 UNIT/ML CARTRIDGE	57	$24,154.67
NOVOLOG 100 UNIT/ML VIAL	571	$217,621.04
NOVOLOG 100 UNITS/ML FLEXPEN	1373	$668,274.08
NOVOLOG MIX 70-30 FLEXPEN SYRN	89	$42,516.46
TOUJEO SOLOSTAR 300 UNITS/ML	4	$2,920.96
Totals 803 recipients	**6845**	**$3,142,196.48**

References:

1. Facts & Comparisons eAnswers. Accessed online November 11, 2015.

PRODUCT DETAILS OF INHALED CORTICOSTEROIDS

INDICATIONS AND USE:

QVAR (beclomethasone dipropionate)

- Maintenance and prophylactic treatment of asthma in patients 5 years and older.
- Treatment of asthma in patients who require oral corticosteroid therapy.

Pulmicort Flexhaler (budesonide)

- Powder for inhalation – Maintenance treatment of asthma as prophylactic therapy in patients 6 years and older.

Alvesco (ciclesonide)

- Maintenance treatment of asthma as prophylactic therapy in adult and adolescent patients 12 years of age and older.

Aerospan (flunisolide)

- Maintenance treatment of asthma as prophylactic therapy in adult and pediatric patients 6 years and older.
- To reduce or eliminate the need for oral corticosteroids in steroid-dependent asthma patients.

Arnuity Ellipta (fluticasone furoate inhalation powder)

- Maintenance treatment of asthma as prophylactic therapy in patients aged 12 years and older.

Flovent HFA (fluticasone propionate inhalation aerosol)

- Maintenance treatment of asthma as prophylactic therapy in patients aged 4 years and older.
- Treatment of asthma in patients requiring oral corticosteroid therapy.

Flovent Diskus (fluticasone propionate inhalation powder)

- Maintenance treatment of asthma as prophylactic therapy in patients aged 4 years and older.
- Treatment of asthma patients requiring oral corticosteroid therapy.

Asmanex HFA (mometasone furoate inhalation aerosol)

- Maintenance treatment of asthma as prophylactic therapy in patients 12 years of age and older.

Asmamex Twisthaler (mometasone furoate inhalation powder)

- Maintenance treatment of asthma as prophylactic therapy in patients 4 years of age and older.

DOSAGE FORMS:

- QVAR – Inhalation aerosol containing 40 or 80 mcg per actuation.
- Pulmicort Flexhaler – Inhalation powder containing 90 mcg or 180 mcg doses.
- Alvesco – Inhalation aerosol containing 80 or 160 mcg per actuation.
- Aerospan – Inhalation aerosol containing 80 mcg doses.
- Arnuity Ellipta – Inhalation powder containing 100 or 200 mcg per actuation.
- Flovent HFA – Inhalation aerosol containing 44, 110, or 220 mcg doses.
- Flovent Diskus – Inhalation powder containing 50, 100, or 250 mcg doses.
- Asmanex HFA – Inhalation aerosol containing 100 or 200 mcg per actuation.
- Asmanex Twisthaler – Inhalation powder containing 100 or 200 mcg per actuation.

ADMINISTRATION:

QVAR

- Treatment of asthma in patients aged 12 years and older (previous therapy bronchodilators alone): 40 to 80 mcg twice daily not to exceed 320 mcg twice daily.
- Treatment of asthma in patients aged 12 years and older (previous therapy inhaled corticosteroids): 40 to 160 mcg twice daily not to exceed 320 mcg twice daily.
- Treatment of asthma in patients aged 5 – 11 years (previous therapy bronchodilators alone or inhaled corticosteroids): 40 mcg twice daily not to exceed 80 mcg twice daily.

Pulmicort Flexhaler

- Treatment of asthma in patients aged 18 years of age and older: The recommended starting dosage is 360 mcg twice daily. In some patients a starting dose of 180 mcg twice daily may be adequate. Not to exceed 720 mcg twice daily.
- Treatment of asthma in patients 6 to 17 years of age: The recommended starting dosage is 180 mcg twice daily. In some pediatric patients, a starting dose of 360 mcg twice daily may be appropriate. Not to exceed 360 mcg twice daily.

Alvesco

- Patients ≥ 12 years who received bronchodilators alone: 80 mcg twice daily not to exceed 160 mcg twice daily.
- Patients ≥ 12 years who received inhaled corticosteroids: 80 mcg twice daily not to exceed 320 mcg twice daily.
- Patients ≥ 12 years who received oral corticosteroids: 320 mcg twice daily not to exceed 320 mcg twice daily.

Aerospan

- Adults and adolescents (12 years of age and older): The recommended starting dose is 160 mcg twice daily not to exceed 320 mcg twice daily.
- Children (6 to 11 years): The recommended starting dose is 80 mcg twice daily not to exceed 160 mcg twice daily. Administer under adult supervision.

Arnuity Ellipta

- Treatment of asthma in patients 12 years and older: 1 inhalation once daily based on prior asthma therapy and disease severity.

Flovent HFA

- Patients aged 12 years and older who received bronchodilators alone: 88 mcg twice daily not to exceed 440 mcg twice daily.
- Patients aged 12 years and older who received inhaled corticosteroids: 88 – 220 mcg twice daily not to exceed 440 mcg twice daily.
- Patients aged 12 years and older receiving oral corticosteroids: 440 mcg twice daily not to exceed 880 mcg twice daily.
- Patients aged 4 – 11 years: 88 mcg twice daily not to exceed 88 mcg twice daily.

Flovent Diskus

- Patients aged 12 years and older who received bronchodilators alone: 100 mcg twice daily not to exceed 500 mcg twice daily.
- Patients aged 12 years and older who received inhaled corticosteroids: 100 – 250 mcg twice daily not to exceed 500 mcg twice daily.
- Patients aged 12 years and older who received oral corticosteroids: 500 – 1,000 mcg twice daily not to exceed 1,000 mcg twice daily.
- Patients aged 4 – 11 years: 50 mcg twice daily not to exceed 100 mcg twice daily.

Asmanex HFA

- Patients aged 12 years and older: 2 inhalations twice daily based on prior asthma therapy.

Asmanex Twisthaler

- Patients aged 12 years and older who received bronchodilators alone: 220 mcg once daily in the evening not to exceed 440 mcg.
- Patients aged 12 years and older who received inhaled corticosteroids: 220 mcg once daily in the evening not to exceed 440 mcg.
- Patients aged 12 years and older who received oral corticosteroids: 440 mcg twice daily not to exceed 880 mcg.
- Patients 4-11 years of age: 110 mcg once daily in the evening not to exceed 110 mcg.

WARNINGS AND PRECAUTIONS:

- Risk of impaired adrenal function when transferring from oral steroids
- Localized infections
- Deterioration of asthma and acute episodes
- Paradoxical bronchospasm
- Hypersensitivity reactions
- Effects on growth
- Decreases in bone mineral density
- Glaucoma and cataracts

ADVERSE REACTIONS:

QVAR – The most common adverse reactions in clinical trials (≥ 3%) are headache, pharyngitis, oral symptoms and sinusitis.

Pulmicort – The most common adverse reactions in clinical trials (≥ 1%) are nasopharyngitis, nasal congestion, pharyngitis, rhinitis allergic, viral upper respiratory tract infection, nausea, viral gastroenteritis, otitis media, oral candiadiasis.

Alvesco – The most common adverse reactions in clinical trials (≥ 3%) are headache, nasopharyngitis, sinusitis, pharyngolaryngeal pain, upper respiratory infection, arthralgia, nasal congestion, pain in extremity, and back pain.

Aerospan – The most common adverse reactions are pharyngitis, rhinitis, headache, sinusitis, and increased cough.

Arnuity Ellipta – The most common adverse reactions in clinical trials (≥ 5%) are upper respiratory tract infection, nasopharyngitis, headache, and bronchitis.

Flovent Diskus– The most common adverse reactions in clinical trials (> 3%) include upper respiratory tract infection or inflammation, throat irritation, sinusitis, rhinitis, oral candidiasis, nausea and vomiting, gastrointestinal discomfort, fever, cough, bronchitis, and headache.

Flovent HFA – The most common adverse reactions in clinical trials (> 3%) include upper respiratory tract infections or inflammation, throat irritation, sinusitis, dysphonia, candidiasis, cough, bronchitis, and headache.

Asmanex HFA – The most common adverse reactions (≥3%) are headache, nasopharyngitis, sinusitis, bronchitis, and influenza.

Asmanex Twisthaler – The most common adverse reactions (≥5%) are headache, allergic rhinitis, pharyngitis, upper respiratory tract infection, sinusitis, oral candidiasis, dysmenorrhea, musculoskeletal pain, back pain, and dyspepsia.

UTILIZATION

ND Medicaid Inhaled Corticosteroid Utilization		
8/25/14 - 08/24/15		
Label Name	**Rx Num**	**Total Reimb Amt**
ALVESCO 160 MCG INHALER	7	$1,479.53
ALVESCO 80 MCG INHALER	18	$3,896.30
ASMANEX HFA 100 MCG INHALER	3	$543.23
ASMANEX HFA 200 MCG INHALER	1	$49.37
ASMANEX TWISTHALER 110 MCG #30	47	$6,422.85
ASMANEX TWISTHALER 220 MCG #30	18	$2,739.73
ASMANEX TWISTHALER 220 MCG #60	61	$11,635.91
ASMANEX TWISTHALR 220 MCG #120	6	$1,267.20
FLOVENT 100 MCG DISKUS	26	$3,805.62
FLOVENT 250 MCG DISKUS	10	$2,056.88
FLOVENT 50 MCG DISKUS	8	$786.68
FLOVENT HFA 110 MCG INHALER	620	$115,621.04
FLOVENT HFA 220 MCG INHALER	137	$44,110.36
FLOVENT HFA 44 MCG INHALER	477	$63,117.95
PULMICORT 180 MCG FLEXHALER	151	$27,738.63
PULMICORT 90 MCG FLEXHALER	79	$11,053.63
QVAR 40 MCG ORAL INHALER	105	$13,985.52
QVAR 40 MCG ORAL INHALER	29	$3,734.12
QVAR 80 MCG ORAL INHALER	69	$13,831.36
QVAR 80 MCG ORAL INHALER	33	$6,096.13
758 recipients	**1905**	**$333,972.04**

References:

1. QVAR [package insert]. Northridge, CA: 3M Drug Delivery Systems; July 2014.
2. Pulmicort [package insert]. Wilmington, DE: AstraZeneca LP; July 2010.
3. Alvesco [package insert]. Marlborough, MA: Sunovion Pharmaceuticals, Inc.; January 2013.
4. Aerospan [package insert]. Northridge, CA: 3M Drug Delivery Systems; August 2013.
5. Arnuity Ellipta [package insert]. Research Triangle Park, NC: GlaxoSmithKline; November 2014.
6. Flovent HFA [package insert]. Research Triangle Park, NC: GlaxoSmithKline; December 2014.
7. Flovent Diskus [package insert]. Research Triangle Park, NC: GlaxoSmithKline; May 2014.
8. Asmanex Twisthaler [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; September 2014.
9. Asmanex HFA [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; August 2014.

PRODUCT DETAILS OF DIGESTIVE ENZYMES

INDICATIONS AND USE:

- Treatment of exocrine pancreatic insufficiency caused by cystic fibrosis or other conditions.
- Creon is also approved for patients with chronic pancreatitis or pancreatectomy.
- Viokace, in combination with a proton pump inhibitor, is approved for use in adults with exocrine pancreatic insufficiency caused by chronic pancreatitis or pancreatectomy.

DOSAGE FORMS:

- These agents are formulated as delayed-release capsules to delay drug release until entering the lower digestive tract.
- Viokase is the only agent that is not delayed-release and must be administered with a proton pump inhibitor to reduce gastric pH and prevent enzymatic breakdown.

ADMINISTRATION:

- Adult maximum dose: 2,500 lipase units/kg per meal; 10,000 lipase units/kg/day; or 4,000 lipase units/g of fat ingested per day. Initial dose 500 lipase units/kg per meal (up to the maximum dose)
- Children maximum dose: 2,500 lipase units/kg per meal; 10,000 lipase units/kg/day; or 4,000 lipase units/g of fat ingested per day.
- Viokase is not approved for use in pediatric patients. Pertzye is not approved for use in children younger than 1 year.
- Initiate therapy at lowest recommended dose.
- Adjust dose based on body weight, clinical symptoms, and stool fat content. Allow several days between dose adjustments.

WARNINGS AND PRECAUTIONS:

- Fibrosing colonopathy
- Mucosal irritation
- Gout/hyperuricemia
- Hypersensitivity reactions
- Renal function impairment

UTILIZATION

ND Medicaid Digestive Enzymes Utilization		
08/25/14 - 08/24/15		
Label Name	**Rx Num**	**Total Reimb Amt**
CREON DR 12,000 UNITS CAPSULE	60	$41,061.44
CREON DR 24,000 UNITS CAPSULE	21	$34,908.18
CREON DR 3,000 UNITS CAPSULE	10	$3,007.26
CREON DR 6,000 UNITS CAPSULE	6	$3,994.23
PANCREAZE DR 10,500 UNIT CAP	6	$1,549.43
PANCREAZE DR 4,200 UNIT CAP	7	$605.98
ZENPEP DR 10,000 UNITS CAPSULE	26	$19,055.08
ZENPEP DR 20,000 UNITS CAPSULE	22	$21,070.32
Totals 32 recipients	**158**	**$125,251.92**

References:

1. Facts & Comparisons eAnswers. Accessed online November 11, 2015.

PRODUCT DETAILS OF NASAL STEROIDS

INDICATIONS AND USE:

Dymista (azelastine/fluticasone)

- Relief of symptoms of seasonal allergic rhinitis in patients 6 years and older.

Beconase AQ/Qnasl (beclomethasone)

- Prevention of recurrence of nasal polyps following surgical removal.(Beconase AQ only)
- Relief of symptoms of seasonal or perennial allergic and nonallergic (vasomotor) rhinitis.

Rhinocort (budesonide) – available generically

- For the management of nasal symptoms of seasonal or perennial allergic rhinitis in adults and children 6 years and older.

Omnaris/Zetonna (ciclesonide)

- For the treatment of nasal symptoms associated with perennial allergic rhinitis in adults and adolescents 12 years and older.
- For the treatment of nasal symptoms associated with seasonal allergic rhinitis in adults and children 6 years and older (Omnaris) or adults and adolescents 12 years and older (Zetonna).

Flunisolide

- For the relief and management of nasal symptoms of seasonal and perennial allergic rhinitis.

Flonase OTC/Veramyst (fluticasone) available generically

- Management of the nasal symptoms of perennial non-allergic rhinitis in adults and pediatric patients 4 years and older (Rx labeling).
- Relief of hay fever or other upper respiratory allergies (e.g., nasal congestion, runny nose, sneezing, itchy nose) in patients 4 years and older (OTC labeling).
- Treatment of the symptoms of seasonal and perennial allergic rhinitis in patients 2 years and older. (Veramyst)

Nasonex (mometasone)

- Treatment of the nasal symptoms of seasonal allergic and perennial allergic rhinitis in adults and children 2 years and older.
- Relief of nasal congestion associated with seasonal allergic rhinitis in adults and children 2 years and older.
- Treatment of nasal polyps in patients 18 years and older.
- Prophylaxis of the nasal symptoms of seasonal allergic rhinitis in adults and children 12 years and older.

Nasacort OTC/Triamcinolone RX (triamcinolone)

- Management of seasonal and perennial allergic rhinitis in adults and children 2 years and older (RX).
- For the relief of hay fever and other upper respiratory allergies (e.g., nasal congestion, runny nose, sneezing, itchy nose) in adults and children 2 years and older (OTC).

ADMINISTRATION:

Dymista

- Adults and children 6 years of age and older: 1 spray per nostril twice daily.

Beconase/Qnasl

- Adult and children 12 years of age and older: 1 or 2 inhalations in each nostril twice daily not to exceed 336 mcg/day. (Beconase)
- Children 6 to 12 years of age: Start with 1 inhalation in each nostril twice daily up to 336 mcg/day. Once adequate control is achieved, the dosage should be decreased to 84 mcg twice daily. (Beconase)
- Adults and children 12 years and older: 2 inhalations in each nostril once daily up to 320 mcg/day. (Qnasl)
- Children 4 to 11 years of age: 1 inhalation in each nostril once daily. (Qnasl)

Rhinocort Aqua – available generically

- Adults and children 12 years of age and older: 256 mcg/day (4 sprays per nostril once daily).
- Children 6 to younger than 12 years of age: 128 mcg/day (2 sprays per nostril once daily).

Omnaris/Zetonna

- Adults and children 12 years of age and older: 2 sprays per nostril once daily. (Omnaris)
- Adults and children 12 years of age and older: 1 spray per nostril once daily not to exceed 74 mcg/day. (Zetonna)

Flunisolide

- Adults and children 15 years of age and older: 2 sprays in each nostril 2 times per day. The dose may be increased to 2 sprays in each nostril 3 times per day.
- Children 6 to 14 years of age: 1 spray in each nostril 3 times per day or 2 sprays in each nostril 2 times per day.

Flonase OTC/Fluticasone/Veramyst

- Adults and children 12 years of age and older (Flonase OTC): 2 sprays per nostril once daily for 1 week. Maintenance – 1 or 2 sprays per nostril once daily. Do not use more than 6 months unless instructed by a health care provider.
- Children 4 to 11 years of age: 1 spray per nostril once daily (Flonase OTC).
- Adults and children 12 years of age and older (Veramyst): 2 sprays per nostril once daily. Maintenance: 1 spray per nostril once daily.
- Children 2 to 11 years of age (Veramyst): 1 spray per nostril once daily.

Nasonex

- Adults and children 12 years of age and older: 2 sprays in each nostril once daily.
- Children 2 to 11 years of age: 1 spray in each nostril once daily.

Nasacort OTC/Triamcinolone RX

- Adults and children 12 years of age and older: 220 mcg/day as 2 sprays in each nostril once daily. Once symptoms have been controlled, reduce dosage to 110 mcg/day as 1 spray in each nostril once daily.
- Children 6 to 12 years of age: Initial dose 110 mcg/day as 1 spray in each nostril once daily.
- Children 2 to 5 years of age: 110 mcg/day as 1 spray in each nostril once daily.

WARNINGS AND PRECAUTIONS:

- Adrenal suppression
- Ophthalmic effects
- Localized infections
- Localized nasal effects
- Delayed wound healing
- Respiratory effects
- Hepatic function impairment
- Effects on growth

UTILIZATION

ND Medicaid Nasal Steroid Utilization		
8/25/14 - 08/24/15		
Label Name	**Rx Num**	**Total Reimb Amt**
BECONASE AQ 0.042% SPRAY	9	$1,868.26
FLUNISOLIDE 0.025% SPRAY	6	$275.43
FLUTICASONE PROP 50 MCG SPRAY	4079	$62,027.03
NASONEX 50 MCG NASAL SPRAY	579	$102,036.11
OMNARIS 50 MCG NASAL SPRAY	4	$685.69
QNASL 80 MCG NASAL SPRAY	12	$1,775.72
RHINOCORT AQUA NASAL SPRAY	8	$1,312.04
TRIAMCINOLONE 55 MCG NASAL SPR	160	$10,558.28
VERAMYST 27.5 MCG NASAL SPRAY	89	$13,559.29
ZETONNA 37 MCG NASAL SPRAY	3	$524.70
Totals	**4949**	**$194,622.55**

References:

1. Facts & Comparisons eAnswers. Accessed online November 11, 2015.

PRODUCT DETAILS OF OTIC ANTI-INFECTIVES

INDICATIONS AND USE:

Ciprodex (ciprofloxacin/dexamethasone)

- Treatment of acute otitis externa in pediatric patients 6 months and older and adults due to susceptible isolates of *Staphylococcus aureus* and *Pseudomonas aeruginosa.*
- Treatment of acute otitis media in pediatric patients 6 months and older with tympanostomy tubes due to susceptible isolates of *S. aureus*, *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Moraxella catarrhalis,* and *P. aeruginosa.*

Ciprofloxacin

- For the treatment of acute otitis externa caused by susceptible isolates of *Pseudomonas aeruginosa* or*Staphylococcus aureus.*

Ofloxacin

- For the treatment of acute otitis media in children 1 year of age and older with tympanostomy tubes due to *Staphylococcus aureus*, *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Moraxella catarrhalis*, and *Pseudomonas aeruginosa.*
- For the treatment of chronic suppurative otitis media in patients 12 years of age and older with perforated tympanic membranes caused by *Proteus mirabilis*, *P. aeruginosa*, and *S. aureus.*
- For the treatment of otitis externa in adults and children 6 months of age and older, caused by *Escherichia coli, P. aeruginosa, and S. aureus.*

ADMINISTRATION:

Ciprodex

- Adults and children 6 months of age and older: Instill 4 drops into affected ear(s) twice daily for 7 days.

Ciprofloxacin

- Adults and children 1 year of age and older: Instill into the affected ear twice daily (approximately 12 hours apart) for 7 days.

Ofloxacin

- Chronic suppurative otitis media – adults and children 12 years of age and older instill 10 drops into the affected ear twice daily for 14 days.
- Otitis externa – adults and children 13 years of age and older instill 10 drops into the affected ear once daily for 7 days. Children 6 months to 13 years of age instill 5 drops into the affected ear once daily for 7 days.
- Acute otitis media – children 1-2 with tympanostomy tubes instill 5 drops into the affected ear twice daily for 10 days.

WARNINGS AND PRECAUTIONS:

- For otic use
- Tendon inflammation/rupture
- Auditory impairment
- Hypersensitivity reaction
- Superinfection
- Arthropathy

UTILIZATION

ND Medicaid Otic Anti-infectives Utilization		
8/25/14 - 08/24/15		
Label Name	**Rx Num**	**Total Reimb Amt**
CIPRODEX OTIC SUSPENSION	834	$133,590.68
OFLOXACIN 0.3% EAR DROPS	600	$18,291.76
Totals	**1434**	**$151,882.44**

References:

1. Facts & Comparisons eAnswers. Accessed online November 11, 2015.

PRODUCT DETAILS OF ULCER ANTI-INFECTIVES

INDICATIONS AND USE:

- Pylera – In combination with omeprazole for the treatment of patients with *H. pylori* infection and duodenal ulcer disease (active or history of within the past 5 years) to eradicate *H. pylori*.
- Prevpac (generic available) – Eradication of *H. pylori* infection to reduce the risk of recurrent duodenal ulcer in patients with active or 1-year history of duodenal ulcer.
- Omeclamox – Eradication of *H. pylori* infection to reduce the risk of recurrent duodenal ulcer in adults with active or 1-year history of duodenal ulcer.

DOSAGE FORMS:

- Pylera: 140 mg of bismuth subcitrate potassium; 125 mg of metronidazole; 125 mg of tetracycline
- Prevpac: 30 mg of lansoprazole; 1,000 mg of amoxicillin; 500 mg clarithromycin
- Omeclamox: 20 mg of omeprazole; 500 mg of clarithromycin; 1,000 mg amoxicillin

ADMINISTRATION:

- Pylera: Each dose of Pylera should be taken 4 times a day, after meals and at bedtime for 10 days. Administer with omeprazole 20 mg twice daily (after the morning and evening meals).
- Prevpac: Each dose should be administered twice daily (morning and evening) for 10 or 14 days.
- Omeclamox: Each dose should be administered twice daily for 10 days in the morning and evening before eating a meal. In patients with an ulcer present at initiation of therapy, an additional 18 days of omeprazole 20 mg once daily is recommended.

WARNINGS AND PRECAUTIONS:

- Fetal toxicity
- Maternal toxicity
- Central and peripheral nervous system effects (Pylera)
- Development of superinfection
- Photosensitivity (Pylera)
- Acute Hypersensitivity Reactions (Prevpac and Omeclamox)
- Hepatotoxicity (Prevpac)
- QT Prolongation (Prevpac)
- Gastric malignancy
- Myasthenia gravis (Omeclamox)

UTILIZATION

ND Ulcer Anti-infective Utilization		
08/25/14 - 08/24/15		
Label Name	**Rx Num**	**Total Remb Amt**
LANSOPRAZOL-AMOXICIL-CLARITHRO	34	$18,024.24
PYLERA CAPSULE	6	$3,326.35
PREVPAC PATIENT PACK	41	$6,321.96
Totals 78 recipients	**81**	**$27,672.55**

References:

1. Facts & Comparisons eAnswers. Accessed online November 11, 2015.

NORTH DAKOTA MEDICAID
RETROSPECTIVE DRUG UTILIZATION REVIEW
CRITERIA RECOMMENDATIONS
4TH QUARTER 2015

Criteria Recommendations ***Approved Rejected***

1. Netupitant/Palonosetron / Strong CYP3A4 Inhibitors _____ _____

Alert Message: Caution should be exercised when co-administering Akynzeo (netupitant/palonosetron) with a strong CYP3A4 inhibitor. The netupitant component of the combination product is a CYP3A4 substrate and use with a strong CYP3A4 inhibitor can significantly increase netupitant systemic exposure.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Netupitant/palonosetron	Nefazodone	Ketoconazole	
	Clarithromycin	Itraconazole	
	Telithromycin	Voriconazole	
	Boceprevir	Posaconazole	
	Saquinavir	Cobicistat	
	Ritonavir		
	Indinavir		
	Nelfinavir		

References:
Akynzeo Prescribing Information, April 2015, EISAI, Inc.
FDA: Drug Development and Drug Interactions: Tables of Substrates, Inhibitors and Inducers. Available at: http://www.fda.gov/Drugs/DevelopmentApprovalProcess/DevelopmentResources/DrugInteractionaLabeling/ucm093664.htm

2. Netupitant/Palonosetron / Strong CYP3A4 Inducers _____ _____

Alert Message: Concurrent use of Akynzeo (netupitant/palonosetron) in patients who are chronically using a strong CYP3A4 inducer should be avoided. The netupitant component of the combination product is a CYP3A4 substrate and use with a potent CYP3A4 inducer can substantially decrease netupitant plasma concentrations.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Netupitant/palonosetron	Phenytoin	
	Phenobarbital	
	Primidone	
	Carbamazepine	
	Rifampin	

References:
Akynzeo Prescribing Information, April 2015, EISAI, Inc.

3. Netupitant/Palonosetron / CYP3A4 Substrates _____ _____

Alert Message: Akynzeo (netupitant/palonosetron) should be used with caution in patients receiving concomitant medications that are primarily metabolized through CYP3A4. The netupitant component of the combination product is a moderate CY3A4 inhibitor and its inhibitory effect on CYP3A4 metabolism can last for multiple days. Monitor patients for increased pharmacologic effects of the 3A4 substrate.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B			Util C
Netupitant/palonosetron	Dexamethasone	Eletriptan	Crizotinib	
	Midazolam	Eszopiclone	Dasatinib	
	Alprazolam	Ethosuximide	Erlotinib	
	Triazolam	Galantamine	Ibrutinib	
	Docetaxel	Hydrocodone	Lapatinib	
	Paclitaxel	Loratadine	Nilotinib	
	Etoposide	Lurasidone	Pazopanib	
	Irinotecan	Maraviroc	Sunitinib	
	Cyclophosphamide	Oxycodone	Vandetanib	
	Ifosfamide	Prasugrel	Sildenafil	
	Imatinib	Quazepam	Vardenafil	
	Vinorelbine	Simvastatin	Avanafil	
	Vinblastine	Lovastatin	Fosamprenavir	
	Vincristine	Tadalafil	Atazanavir	
	Apixaban	Tiagabine	Tipranavir	
	Bortezomib	Ticagrelor	Delavirdine	
	Bosutinib	Vilazodone		
	Buprenorphine	Axitinib		
	Clomipramine	Cabozantinib		
	Disulfiram	Ceritinib		

References:
Akynzeo Prescribing Information, April 2015, EISAI, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

4. Netupitant/Palonosetron / Severe Hepatic, Sev. Renal Impairment & ESRD _____ _____

Alert Message: Akynzeo (netupitant/palonosetron) use should be avoided in patients with severe hepatic impairment, severe renal impairment or end-stage renal disease (ESRD). Limited data are available with netupitant/palonosetron in patients with severe hepatic impairment. The netupitant component has not been studied in patients and the pharmacokinetics for netupitant and palonosetron has not been studied in patient with ESRD requiring dialysis.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Netupitant/palonosetron		Severe Hepatic Impairment
		CKD Stage 4 & 5
		ESRD

References:
Akynzeo Prescribing Information, April 2015, EISAI, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

5. Netupitant/Palonosetron / Therapeutic Appropriateness < 18 yoa _____ _____

Alert Message: Safety and effectiveness of Akynzeo (netupitant/palonosetron) in patients below the age of 18 years have not been established.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Netupitant/palonosetron		

Age Range: 0-17 yoa

References:
Akynzeo Prescribing Information, Oct. 2014, EISAI, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

6. Netupitant/Palonosetron / Serotoninergic Agents _____ _____

Alert Message: Concurrent use of Akynzeo (netupitant/palonosetron) with another serotonergic agent may result in additive serotonergic effects increasing the risk of adverse events including serotonin syndrome (e.g., mental status changes, neuromuscular symptoms and seizures). The palonosetron component of the fixed combination product is a 5HT3 receptor antagonist which blocks serotonin.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Netupitant/Palonosetron	SSRIs	
	SNRIs	
	MAOIs	
	TCAs	
	Mirtazapine	
	Dextromethorphan	
	Fentanyl	
	Lithium	
	Linezolid	
	Meperidine	
	Pentazocine	
	Rasagiline	
	Selegiline	
	Tramadol	
	Triptans	

References:
Akynzeo Prescribing Information, April 2015, EISAI, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

7. Viekira Pak / Viekira Pak Contraindicated Drugs _____ _____

Alert Message: A review of recent pharmacy claims show that the patient is receiving concurrent therapy with Viekira Pak (ombitasvir/paritaprevir/ritonavir & dasabuvir) and a drug that is contraindicated with this combination product. Co-administration of Viekira Pak with the identified agent(s) may result in serious and/or life-threatening events.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Viekira Pak	Alfuzosin	Lurasidone
	Carbamazepine	Ziprasidone
	Phenytoin	Dronedarone
	Phenobarbital	Eplerenone
	Gemfibrozil	
	Rifampin	
	Ergotamine	
	Dihydroergotamine	
	Methylergonovine	
	Lovastatin	
	Simvastatin	
	Pimozide	
	Efavirenz	
	Revatio	
	Triazolam	
	Midazolam	
	Amiodarone	
	Flecainide	
	Propafenone	
	Quinidine	
	Ethinyl estradiol-containing products	

References:
Viekira Pak Prescribing Information, March 2015, AbbVie Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

8. Viekira Pak / Severe Hepatic Impairment _____ _____

Alert Message: Viekira Pak (ombitasvir/paritaprevir/ritonavir & dasabuvir) is contraindicated in patients with severe hepatic impairment due to the risk of potential toxicity and its use is not recommended in HCV-infected patients with moderate hepatic impairment (Child-Pugh B).] No dosage adjustment is required in patients with mild hepatic impairment.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C
Viekira Pak	Hepatic Impairment	

References:
Viekira Pak Prescribing Information, March 2015, AbbVie Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

9. Viekira Pak / Mexiletine _____ _____

Alert Message: Concurrent use of Viekira Pak (ombitasvir/paritaprevir/ritonavir & dasabuvir) with mexiletine may result in increased mexiletine plasma concentrations due to inhibition, by the ritonavir component in Viekira Pak, of mexiletine CYP2D6-mediated metabolism. The manufacturer recommends caution and therapeutic concentration monitoring (if available) when these agents are co-administered.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Viekira Pak	Mexiletine	

References:
Viekira Pak Prescribing Information, March 2015, AbbVie Inc.

10. Viekira Pak / Disopyramide _____ _____

Alert Message: Concurrent use of Viekira Pak (ombitasvir/paritaprevir/ritonavir & dasabuvir) with disopyramide may result in increased disopyramide plasma concentrations due to inhibition, by the ritonavir component in Viekira Pak, of the disopyramide CYP3A4-mediated metabolism. The manufacturer recommends caution and therapeutic concentration monitoring (if available) when these agents are co-administered.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Viekira Pak	Disopyramide	

References:
Viekira Pak Prescribing Information, March 2015, AbbVie Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

11. Viekira Pak / Ketoconazole _____ _____

Alert Message: The daily dose of ketoconazole should be limited to 200 mg per day when co-administered with Viekira Pak (ombitasvir/paritaprevir/ritonavir & dasabuvir). The ritonavir component of the combination product is a strong CYP3A4 inhibitor and concurrent use with the CYP3A4 substrate, ketoconazole, may result in elevated ketoconazole plasma concentrations increasing the risk for ketoconazole-related adverse effects.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Ketoconazole		Viekira Pak

Max Dose: 200mg/day

References:
Viekira Pak Prescribing Information, March 2015, AbbVie Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

12. Viekira Pak / Voriconazole _____ _____

Alert Message: Concurrent use of Viekira Pak (ombitasvir/paritaprevir/ritonavir & dasabuvir) with Vfend (voriconazole) is not recommended unless an assessment of the benefit-to-risk ratio justifies the use of voriconazole. Drug studies with voriconazole and ritonavir, a component of the combination product, have shown that concomitant use of these agents results in decreased voriconazole concentrations. Co-administration of voriconazole and high-dose ritonavir (400 mg q 12h) is contraindicated.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Viekira Pak	Voriconazole	

References:
Viekira Pak Prescribing Information, March 2015, AbbVie Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

13. Viekira Pak / Calcium Channel Blockers _____ _____

Alert Message: Concurrent use of Viekira Pak (ombitasvir/paritaprevir/ritonavir & dasabuvir) with a calcium channel blocker (CCB) may result in elevated CCB plasma concentrations due to inhibition, by the ritonavir component in Viekira Pak, of the CCB CYP3A4-mediated metabolism. The manufacturer recommends caution and clinical monitoring when these agents are co-administered.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Viekira Pak	Amlodipine	
	Diltiazem	
	Felodipine	
	Isradipine	
	Nicardipine	
	Nifedipine	
	Nimodipine	
	Nisoldipine	
	Verapamil	

References:
Viekira Pak Prescribing Information, March 2015, AbbVie Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

14. Viekira Pak / Fluticasone _____ _____

Alert Message: Concurrent use of Viekira Pak (ombitasvir/paritaprevir/ritonavir & dasabuvir) with fluticasone, a CYP3A4 substrate, may result in increased fluticasone exposure due to inhibition, by the ritonavir component in the Viekira Pak, of fluticasone CYP3A4-mediated metabolism. Elevated fluticasone exposure may cause reduced cortisol concentrations resulting in systemic corticosteroid effects. Then manufacturer recommends consideration of an alternative corticosteroid, particularly for long-term use.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Viekira Pak	Fluticasone	

References:
Viekira Pak Prescribing Information, March 2015, AbbVie Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

15. Viekira Pak / Furosemide _____ _____

Alert Message: Concurrent use of Viekira Pak (ombitasvir/paritaprevir/ritonavir & dasabuvir) with furosemide may result in elevated furosemide maximum plasma concentrations (Cmax). Clinical monitoring of the patient is recommended and furosemide therapy individualized based on patient's clinical response.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Viekira Pak	Furosemide	

References:
Viekira Pak Prescribing Information, March 2015, AbbVie Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

16. Viekira Pak / Atazanavir / Ritonavir _____ _____

Alert Message: Concurrent use of atazanavir (boosted with ritonavir) and Viekira Pak (ombitasvir/paritaprevir/ritonavir & dasabuvir) has resulted in elevated paritaprevir serum concentrations. The manufacturer recommends atazanavir 300 mg (without the ritonavir booster) once daily in the morning when co-administering with Viekira Pak. The antiretroviral regimen should be re-adjusted after completion of the hepatitis C regimen.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Viekira Pak	Atazanavir	Ritonavir

References:
Viekira Pak Prescribing Information, March 2015, AbbVie Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

17. Viekira Pak / Darunavir / Ritonavir _____ _____

Alert Message: Concurrent use of Viekira Pak (ombitasvir/paritaprevir/ritonavir & dasabuvir) with darunavir and ritonavir is not recommended due to potential for decreased darunavir plasma concentrations.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Viekira Pak	Darunavir	Ritonavir

References:
Viekira Pak Prescribing Information, March 2015, AbbVie Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

18. Viekira Pak / Lopinavir-Ritonavir _____ _____

Alert Message: Concurrent use of Viekira Pak (ombitasvir/paritaprevir/ritonavir & dasabuvir) with Kaletra (lopinavir/ritonavir) is not recommended due to the potential for increased plasma concentrations of the paritaprevir component of the combination HCV product.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Viekira Pak	Lopinavir/Ritonavir	

References:
Viekira Pak Prescribing Information, March 2015, AbbVie Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

19. Viekira Pak / Rilpivirine _____ _____

Alert Message: Concurrent use of Viekira Pak (ombitasvir/paritaprevir/ritonavir & dasabuvir) with Edurant (rilpivirine) is not recommended due to the potential for increased plasma concentrations of rilpivirine and risk of QT interval prolongation.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Viekira Pak	Rilpivirine	

References:
Viekira Pak Prescribing Information, March 2015, AbbVie Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

20. Viekira Pak / Rosuvastatin 20 & 40 mg _____ _____

Alert Message: The dose of Crestor (rosuvastatin) should not exceed 10 mg per day when co-administered with Viekira Pak (ombitasvir/paritaprevir/ritonavir & dasabuvir). Rosuvastatin is a CYP3A4, BCRP, OATP1B1, and OATP1B3 substrate. The components of Viekira Pak inhibit CYP3A4-mediated metabolism and BCRP-, OATP1B1-, and OATP1B3-mediated transport. Concurrent use of these agents may result in increased rosuvastatin plasma concentrations and risk of rosuvastatin-related adverse effects (e.g., myopathy and rhabdomyolysis).

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Viekira Pak	Rosuvastatin 20 & 40 mg	

References:
Viekira Pak Prescribing Information, March 2015, AbbVie Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

21. Viekira Pak / Pravastatin 80 mg _____ _____

Alert Message: The dose of pravastatin should not exceed 40 mg per day when co-administered with Viekira Pak (ombitasvir/paritaprevir/ritonavir & dasabuvir). Pravastatin is a CYP3A4 and OATP1B1 substrate. The components of Viekira Pak inhibit CYP3A4-mediated metabolism and OATP1B1-mediated transport. Concurrent use of these agents may result in increased pravastatin plasma concentrations and risk of pravastatin-related adverse effects (e.g., myopathy and rhabdomyolysis).

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Viekira Pak	Pravastatin 80mg	

References:
Viekira Pak Prescribing Information, March 2015, AbbVie Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

22. Viekira Pak / Salmeterol _____ _____

Alert Message: Concurrent use of Viekira Pak (ombitasvir/paritaprevir/ritonavir & dasabuvir) with a salmeterol-containing agent is not recommended due to the increased risk of salmeterol-related adverse reactions, particularly cardiovascular effects (e.g., QT prolongation, palpitations, & tachycardia). The ritonavir component in Viekira Pak product inhibits the CYP3A4-mediated metabolism of salmeterol resulting in elevated salmeterol plasma concentrations.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Viekira Pak	Salmeterol	

References:
Viekira Pak Prescribing Information, March 2015, AbbVie Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

23. Viekira Pak / Buprenorphine _____ _____

Alert Message: Concurrent use of Viekira Pak (ombitasvir/paritaprevir/ritonavir & dasabuvir) with a buprenorphine-containing agent may result in increased buprenorphine plasma concentrations due to inhibition, by the ritonavir component in Viekira Pak, of buprenorphine CYP3A4-mediated metabolism. No dosage adjustment is required; however, close monitoring for sedation and cognitive effects is advised.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Viekira Pak	Buprenorphine	

References:
Viekira Pak Prescribing Information, March 2015, AbbVie Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

24. Viekira Pak / Omeprazole _____ _____

Alert Message: Concurrent use of Viekira Pak (ombitasvir/paritaprevir/ritonavir & dasabuvir) with omeprazole may result in decreased omeprazole plasma concentrations. Monitor patient for decreased omeprazole efficacy and consider increasing the omeprazole dose if necessary, but not to exceed 40 mg per day. The dose may be readjusted after completion of the Viekira Pak regimen.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Viekira Pak	Omeprazole	

References:
Viekira Pak Prescribing Information, March 2015, AbbVie Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

25. Viekira Pak / Alprazolam _____ _____

Alert Message: Concurrent use of Viekira Pak (ombitasvir/paritaprevir/ritonavir & dasabuvir) with alprazolam may result in increased alprazolam plasma concentrations due to inhibition, by the ritonavir component in Viekira Pak, of alprazolam CYP3A4-mediated metabolism. Clinical monitoring for alprazolam-related adverse events is recommended and alprazolam dose reduction can be considered based on clinical response.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Viekira Pak	Alprazolam	

References:
Viekira Pak Prescribing Information, March 2015, AbbVie Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

26. Olopatadine / Therapeutic Appropriateness (Pediatric Use) _____ _____

Alert Message: The safety and effectiveness of Pazeo (olopatadine 0.7% ophthalmic solution) in children younger than 2 years of age have not been established.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Olopatadine 0.7%		

Age Range: 0 – 1 yoa

References:
Facts & Comparisons, 2015, Wolters Kluwer health, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

27. Ledipasvir + Sofosbuvir / Overutilization _____ _____

Alert Message: The recommended dose of Harvoni (ledipasvir/sofosbuvir) is one 90mg/400mg tablet taken once daily with or without food.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Ledipasvir/Sofosbuvir		

Max Dose: 90mg/400mg per day

References:
Harvoni Prescribing Information, March 2015, Gilead Science, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

28. Ledipasvir + Sofosbuvir /Sofosbuvir _____ _____

Alert Message: The concurrent use of Harvoni (ledipasvir/sofosbuvir) with other products containing sofosbuvir is not recommended.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Ledipasvir/Sofosbuvir	Sofosbuvir	

References:
Harvoni Prescribing Information, March 2015, Gilead Science, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

29. Ledipasvir + Sofosbuvir / Therapeutic Appropriateness < 18 yoa _____ _____

Alert Message: Safety and effectiveness of Harvoni (ledipasvir/sofosbuvir) have not been established in pediatric patients.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Ledipasvir/Sofosbuvir		

Age Range: 0-17 yoa

References:
Harvoni Prescribing Information, March 2015, Gilead Science, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

30. Ledipasvir + Sofosbuvir / P-gp Inducers _____ _____

Alert Message: The concurrent use of Harvoni (ledipasvir/sofosbuvir) with a P-gp inducer is not recommended. Both ledipasvir and sofosbuvir are P-gp substrates and co-administration with a P-gp inducer may decrease ledipasvir and sofosbuvir plasma concentrations, leading to reduced antiviral efficacy.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Ledipasvir/Sofosbuvir	Rifampin	
	Carbamazepine	
	Oxcarbazepine	
	Phenytoin	
	Phenobarbital	
	Primidone	
	Rifabutin	
	Rifapentine	

References:
Harvoni Prescribing Information, March 2015, Gilead Science, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

31. Ledipasvir + Sofosbuvir / Tipranavir / Ritonavir _____ _____

Alert Message: The concurrent use of Harvoni (ledipasvir/sofosbuvir) with ritonavir-boosted tipranavir is not recommended. Tipranavir is a P-gp inducer and co-administration with the P-gp substrates ledipasvir and sofosbuvir may result in decreased ledipasvir and sofosbuvir plasma concentrations, leading to reduced antiviral efficacy.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Ledipasvir/Sofosbuvir	Tipranavir	Ritonavir

References:
Harvoni Prescribing Information, March 2015, Gilead Science, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

32. Ledipasvir + Sofosbuvir / Antacids _____ _____

Alert Message: It is recommended to separate the administration of an antacid and Harvoni (ledipasvir/sofosbuvir) by 4 hours. The ledipasvir component of the combo product is pH dependent and drugs that increase gastric pH are expected to decrease ledipasvir solubility and therefore its bioavailability.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Ledipasvir/Sofosbuvir	Aluminum hydroxide	
	Magnesium hydroxide	
	Calcium Carbonate	
	Sodium Bicarbonate	

References:
Harvoni Prescribing Information, March 2015, Gilead Science, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

33. Ledipasvir + Sofosbuvir / H2 Blockers _____ _____

Alert Message: Caution should be exercised when using Harvoni (ledipasvir/sofosbuvir) with an H-2 receptor antagonist. These agents may be administered simultaneously or separated by 12 hours if the dose of the H-2 antagonist does not exceed doses comparable to famotidine 40 mg twice daily. The ledipasvir component of the combo product is pH dependent and drugs that increase gastric pH are expected to decrease ledipasvir solubility and therefore its bioavailability.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Cimetidine > 1600mg/day		Ledipasvir/Sofosbuvir
Famotidine > 80mg/day		
Ranitidine > 600mg/day		
Nizatidine > 600mg/day		

References:
Harvoni Prescribing Information, March 2015, Gilead Science, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

34. Ledipasvir + Sofosbuvir / Proton Pump Inhibitors _____ _____

Alert Message: Caution should be exercised when using Harvoni (ledipasvir/sofosbuvir) with a proton pump inhibitor (PPI). A PPI may be administered simultaneously with ledipasvir/sofosbuvir under fasted conditions if the dose of the PPI does not exceed doses comparable to omeprazole 20 mg daily. The ledipasvir component of the combo product is pH dependent and drugs that increase gastric pH are expected to decrease ledipasvir solubility and therefore its bioavailability.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Omeprazole > 20mg/day		Ledipasvir/Sofosbuvir
Esomeprazole > 20mg/day		
Lansoprazole >30mg/day		
Dexlansoprazole >60mg/day		
Rabeprazole >20 mg/day		
Pantoprazole >40mg/day		

References:
Harvoni Prescribing Information, March 2015, Gilead Science, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

35. Ledipasvir + Sofosbuvir / Digoxin _____ _____

Alert Message: The concurrent use of Harvoni (ledipasvir/sofosbuvir) with digoxin, a P-gp substrate, may result in an increase in the concentration of digoxin due to inhibition, by the ledipasvir component, of the P-gp efflux transporter system. Digoxin therapeutic concentration monitoring is recommended if the drugs are co-administered.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Ledipasvir/Sofosbuvir	Digoxin	

References:
Harvoni Prescribing Information, March 2015, Gilead Science, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

36. Ledipasvir + Sofosbuvir / Efavirenz/Emtricitabine/Tenofovir _____ _____

Alert Message: The concurrent use of Harvoni (ledipasvir/sofosbuvir) with the fixed dose combination product Atripla (efavirenz/emtricitabine/tenofovir) may result in elevated tenofovir plasma concentrations due to the inhibition, by ledipasvir, of P-gp and BCRP transport of tenofovir. Patients should be monitored for tenofovir adverse effects.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Ledipasvir/Sofosbuvir	Efavirenz/Emtricitabine/Tenofovir	

References:
Harvoni Prescribing Information, March 2015, Gilead Science, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard

37. Ledipasvir + Sofosbuvir / Stribild _____ _____

Alert Message: The concurrent use of Harvoni (ledipasvir/sofosbuvir) with the fixed dose combination product Stribild (elvitegravir/cobicistat/emtricitabine/tenofovir) is not recommended. Co-administration of these agents may result in elevated tenofovir concentrations and tenofovir-associated adverse reactions due to the inhibition, by ledipasvir, of P-gp and BCRP transport of tenofovir.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Ledipasvir/Sofosbuvir	Elvitegravir/Cobicistat/Emtricitabine/Tenofovir	

References:
Harvoni Prescribing Information, March 2015, Gilead Science, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

38. Ledipasvir + Sofosbuvir / Simeprevir _____ _____

Alert Message: The concurrent use of Harvoni (ledipasvir/sofosbuvir) with Olysio (simeprevir) is not recommended. Concentrations of ledipasvir and simeprevir are increased when simeprevir is co-administered with ledipasvir.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Ledipasvir/Sofosbuvir	Simeprevir	

References:
Harvoni Prescribing Information, March 2015, Gilead Science, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

39. Ledipasvir + Sofosbuvir / Rosuvastatin _____ _____

Alert Message: The concurrent use of Harvoni (ledipasvir/sofosbuvir) with Crestor (rosuvastatin) is not recommended. Co-administration of these agents may result in a significant increase in the concentration of rosuvastatin which is associated with increased risk of myopathy including rhabdomyolysis.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Ledipasvir/Sofosbuvir	Rosuvastatin	

References:
Harvoni Prescribing Information, March 2015, Gilead Science, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

40. Edoxaban / Overutilization _____ _____

Alert Message: The manufacturer's recommended maximum dose of Savaysa (edoxaban) is 60 mg once daily in patients with CrCL > 50 to ≤ 95 mL/min. The daily dose should not exceed 30 mg once daily in patients with a CrCL of 15 to 50 mL/min or in patients with DVT or PE weighing less than or equal to 60 kg or who use certain P-gp inhibitors. Edoxaban should not be used in patients with CrCl > 95 mL/min because of an increased risk of ischemic stroke.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Edoxaban		Renal Impairment

Max Dose: 60mg/day

References:
Savaysa Prescribing Information, Jan. 2015, Daiichi Sankyo, Inc.

41. Edoxaban / Overutilization _____ _____

Alert Message: The manufacturer's recommended maximum dose of Savaysa (edoxaban) should not exceed 30 mg once daily in patients with a CrCL of 15 to 50 mL/min or in patients with DVT or PE weighing less than or equal to 60 kg or who concurrently use certain P-gp inhibitors. Edoxaban should not be used in patients with CrCl > 95 mL/min because of an increased risk of ischemic stroke.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Edoxaban		CKD Stage 3
		CKD Stage 4

Max Dose: 30mg/day

References:
Savaysa Prescribing Information, Jan. 2015, Daiichi Sankyo, Inc.

42. Edoxaban 60mg / Overutilization _____ _____

Alert Message: The manufacturer's recommended maximum dose of Savaysa (edoxaban) should not exceed 30 mg once daily in patients with a CrCL of 15 to 50 mL/min or in patients with DVT or PE weighing less than or equal to 60 kg or who concurrently use certain P-gp inhibitors. Edoxaban should not be used in patients with CrCl > 95 mL/min because of an increased risk of ischemic stroke.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**		
Edoxaban 60mg	Deep Vein Thrombosis	CKD Stage 3	Azithromycin	Ketoconazole
	Pulmonary Embolism	CKD Stage 4	Clarithromycin	
		Verapamil	Erythromycin	
		Quinidine	Itraconazole	

References:
Savaysa Prescribing Information, Jan. 2015, Daiichi Sankyo, Inc.

43. Edoxaban / Severe Renal Disease (Black Box warning) _____ _____

Alert Message: Savaysa (edoxaban) use is not recommended in patients with CrCL < 15 mL/min. Renal clearance accounts for 50% of the total clearance of edoxaban and edoxaban blood levels are increased in patients with poor renal function as compared to those with higher renal function.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Edoxaban		CKD Stage 5

References:
Savaysa Prescribing Information, Jan. 2015, Daiichi Sankyo, Inc.

44. Edoxaban / Renal Impairment (Negating) _____ _____

Alert Message: Savaysa (edoxaban) should not be used in patients with CrCL > 95 mL/min because of an increased risk of ischemic stroke. Renal clearance accounts for 50% of the total clearance of edoxaban and as renal function improves and edoxaban levels decrease, the risk of ischemic stroke increases.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Edoxaban		Renal Impairment

References:
Savaysa Prescribing Information, Jan. 2015, Daiichi Sankyo, Inc.

45. Edoxaban / Active Pathological Bleed _____ _____

Alert Message: Savaysa (edoxaban) can cause serious, potentially fatal bleeding and is contraindicated in any patient with active pathological bleeding.

Conflict Code: MC - Drug Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C
Edoxaban	Intracranial Hemorrhage	
	Gastrointestinal Hemorrhage	

References:
Savaysa Prescribing Information, Jan. 2015, Daiichi Sankyo, Inc.

46. Edoxaban / Mitral Stenosis & Heart Valve Replacement _____ _____

Alert Message: The safety and efficacy of Savaysa (edoxaban) has not been studied in patients with mechanical heart valves or moderate to severe mitral stenosis. The use of edoxaban is not recommended in these patients.

Conflict Code: MC - Drug Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C
Edoxaban	Mitral Stenosis 394.0	
	Heart Valve Replacement V43.3	

References:
Savaysa Prescribing Information, Jan. 2015, Daiichi Sankyo, Inc.

47. Edoxaban / Antiplatelets, Thrombolytics, Aspirin & NSAIDS _____ _____

Alert Message: Concomitant use of Savaysa (edoxaban) with drugs affecting hemostasis (e.g., aspirin, platelet aggregation inhibitors and NSAIDS) may increase the risk of bleeding. Promptly evaluate any signs or symptoms of blood loss if the patient is treated concurrently with these agents.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Edoxaban	Dipyridamole	
	Ticlopidine	
	Cilostazol	
	Vorapaxar	
	Clopidogrel	
	Prasugrel	
	Ticagrelor	
	Anagrelide	
	Aspirin	
	NSAIDS	

References:
Savaysa Prescribing Information, Jan. 2015, Daiichi Sankyo, Inc.

48. Edoxaban / Anticoagulants _____ _____

Alert Message: Concomitant use of Savaysa (edoxaban) with an anticoagulant may increase the risk of bleeding. Long-term treatment with edoxaban and other anticoagulants is not recommended because of the increased risk of bleeding. Short-term co-administration may be needed for patients transitioning to or from edoxaban.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Edoxaban	Warfarin	
	Apixaban	
	Rivaroxaban	
	Dabigatran	
	Enoxaparin	

References:
Savaysa Prescribing Information, Jan. 2015, Daiichi Sankyo, Inc.

49. Edoxaban / Moderate to Severe Hepatic Impairment _____ _____

Alert Message: The use of Savaysa (edoxaban) in patients with moderate to severe hepatic impairment (Child-Pugh B and C) is not recommended as these patients may have intrinsic coagulation abnormalities. No dose reduction is required in patients with mild hepatic impairment (Child-Pugh A).

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Edoxaban		Hepatic Impairment

References:
Savaysa Prescribing Information, Jan. 2015, Daiichi Sankyo, Inc.

50. Edoxaban / Rifampin _____ _____

Alert Message: Co-administration of Savaysa (edoxaban), a P-gp substrate, with rifampin should be avoided due to the risk of decreased edoxaban efficacy. Rifampin is a potent P-gp inducer and concurrent use with edoxaban may result in decreased edoxaban exposure.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Edoxaban	Rifampin	

References:
Savaysa Prescribing Information, Jan. 2015, Daiichi Sankyo, Inc.

51. Edoxaban / Nonadherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Savaysa (edoxaban). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects (i.e., increasing risk of thrombotic events), which may lead to decreased patient outcomes and additional healthcare costs.

Conflict Code: LR - Nonadherence
Drugs/Diseases

Util A	Util B	Util C
Edoxaban		

References:
Savaysa Prescribing Information, Jan. 2015, Daiichi Sankyo, Inc.
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005;353:487-497.
Kumbhani DJ, Steg PG, Cannon CP, et al. Adherence to Secondary Prevention Medications and Four-year Outcomes in Outpatients with Atherosclerosis. Am J Med.
http://dx.doi.org/10.1016/j.amjmed.2013.01.033.
Kneeland PP, Fang MC. Current Issues in Patient Adherence and Persistence: Focus on Anticoagulants for the Treatment and Prevention of Thromboembolism. Pat Pref Adher 2010;4:51-60.
Ferguson C, Inglis SC, Newton PJ, et al. Atrial Fibrillation and Thromboprophylaxis in Heart Failure: The Need for Patient-Centered Approaches to Address Adherence. Vascular Health and Risk Management 2013;9:3-11.

52. Rivaroxaban / Overutilization _____ _____

Alert Message: The manufacturer's recommended maximum dose of Xarelto (rivaroxaban) is 20 mg once daily with the evening meal in patients with CrCL > 50 mL/min. The daily dose should not exceed 15 mg once daily in patients with a CrCL of 15 to 50 mL/min.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negate)**
Rivaroxaban		CKD 3, 4 & 5

Max Dose: 20mg/day

References:
Xarelto Prescribing Information, Jan. 2015, Janssen Pharmaceuticals, Inc.
Facts & Comparisons, 2015, Wolters Kluwer health, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

53. Rivaroxaban / Overutilization _____ _____

Alert Message: The manufacturer's recommended maximum dose of Xarelto (rivaroxaban) is 15 mg once daily with the evening meal in patients with CrCL of 15 - 50 mL/min.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Rivaroxaban		CKD Stage 3
		CKD Stage 4

Max Dose: 15 mg/day

References:
Xarelto Prescribing Information, Jan. 2015, Janssen Pharmaceuticals, Inc.
Facts & Comparisons, 2015, Wolters Kluwer health, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

54. Rivaroxaban / DVT & PR / CKD Stage 4 & 5 _____ _____

Alert Message: The use of Xarelto (rivaroxaban) should be avoided for DVT prophylaxis and treatment of DVT and/or PE in patients who have a CrCL < 30 mL/min, due to the risk of increased rivaroxaban exposure and pharmacodynamic effects.

Conflict Code: DC – Drug Actual Disease Precaution
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Rivaroxaban	Deep Vein Thrombosis	CKD Stage 4
	Pulmonary Embolism	CKD Stage 5

References:
Xarelto Prescribing Information, Jan. 2015, Janssen Pharmaceuticals, Inc.
Facts & Comparisons, 2015, Wolters Kluwer health, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

55. Rivaroxaban / Active Pathological Bleed _____ _____

Alert Message: Xarelto (rivaroxaban) can cause serious, potentially fatal bleeding and is contraindicated in any patient with active pathological bleeding.

Conflict Code: MC - Drug Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C
Rivaroxaban	Intracranial Hemorrhage	
	Gastrointestinal Hemorrhage	

References:
Xarelto Prescribing Information, Jan. 2015, Janssen Pharmaceuticals, Inc.
Facts & Comparisons, 2015, Wolters Kluwer health, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

56. Rivaroxaban /Heart Valve Replacement _____ _____

Alert Message: The safety and efficacy of Xarelto (rivaroxaban) has not been studied in patients with prosthetic heart valves. The use of rivaroxaban is not recommended in these patients.

Conflict Code: MC - Drug Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C
Rivaroxaban	Heart Valve Replacement (V43.3)	

References:
Xarelto Prescribing Information, Jan. 2015, Janssen Pharmaceuticals, Inc.
Facts & Comparisons, 2015, Wolters Kluwer health, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

57. Rivaroxaban / Antiplatelets, Thrombolytics, Aspirin & NSAIDS _____ _____

Alert Message: Concomitant use of Xarelto (rivaroxaban) with drugs affecting hemostasis (e.g., aspirin, platelet aggregation inhibitors and NSAIDs) may increase the risk of bleeding. Promptly evaluate any signs or symptoms of blood loss if the patient is treated concurrently with these agents.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Rivaroxaban	Dipyridamole	
	Ticlopidine	
	Cilostazol	
	Vorapaxar	
	Clopidogrel	
	Prasugrel	
	Ticagrelor	
	Anagrelide	
	Aspirin	
	NSAIDS	

References:
Xarelto Prescribing Information, Jan. 2015, Janssen Pharmaceuticals, Inc.
Facts & Comparisons, 2015, Wolters Kluwer health, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

58. Rivaroxaban / Anticoagulants _____ _____

Alert Message: Concomitant use of Xarelto (rivaroxaban) with an anticoagulant may increase the risk of bleeding. Avoid the concurrent use of rivaroxaban with other anticoagulants unless the benefit outweighs the risk.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Rivaroxaban	Warfarin	
	Dabigatran	
	Apixaban	
	Enoxaparin	
	Edoxaban	

References:
Xarelto Prescribing Information, Jan. 2015, Janssen Pharmaceuticals, Inc.
Facts & Comparisons, 2015, Wolters Kluwer health, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

59. Rivaroxaban / Hepatic Impairment _____ _____

Alert Message: The use of Xarelto (rivaroxaban) should be avoided in patients with moderate to severe hepatic impairment (Child-Pugh B and C) or with any hepatic disease associated with coagulopathy due to the risk of increased rivaroxaban exposure and bleeding.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Rivaroxaban		Hepatic Impairment

References:
Xarelto Prescribing Information, Jan. 2015, Janssen Pharmaceuticals, Inc.
Facts & Comparisons, 2015, Wolters Kluwer health, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

60. Rivaroxaban / Dual CYP3A4 & P-gp Inducers _____ _____

Alert Message: Concurrent use of Xarelto (rivaroxaban) with a dual P-gp and strong CYP3A4 inducer (e.g., carbamazepine, phenytoin and rifampin) should be avoided. Rivaroxaban is a CYP3A4 and P-gp substrate and use with a dual inducer of CYP3A4-mediated metabolism and P-gp efflux transport may decrease rivaroxaban exposure and increase the risk of stroke.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Rivaroxaban	Rifampin	
	Carbamazepine	
	Phenytoin	

References:
Xarelto Prescribing Information, Jan. 2015, Janssen Pharmaceuticals, Inc.
Facts & Comparisons, 2015, Wolters Kluwer health, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

61. Rivaroxaban / Dual P-gp & Strong CYP3Q4 Inhibitors _____ _____

Alert Message: Concurrent use of Xarelto (rivaroxaban) with a dual P-gp and strong CYP3A4 inhibitor (e.g., ketoconazole, itraconazole, ritonavir, lopinavir/ritonavir, and clarithromycin) should be avoided. Rivaroxaban is a CYP3A4 and P-gp substrate and use with a dual inhibitor of CYP3A4-mediated metabolism and P-gp efflux transport may enhance rivaroxaban exposure and increase bleeding risk.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Rivaroxaban	Ketoconazole	
	Itraconazole	
	Ritonavir	
	Lopinavir/ritonavir	
	Clarithromycin	

References:
Xarelto Prescribing Information, Jan. 2015, Janssen Pharmaceuticals, Inc.
Facts & Comparisons, 2015, Wolters Kluwer health, Inc.
Clinical Pharmacology, 2015 Elsevier/Gold Standard.

62. Rivaroxaban / Nonadherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Xarelto (rivaroxaban). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects (i.e., increasing risk of thrombotic events), which may lead to decreased patient outcomes and additional healthcare costs.

Conflict Code: LR - Nonadherence
Drugs/Diseases

Util A	Util B	Util C
Rivaroxaban		

References: (631, 1664, 1665, 1666)
Xarelto Prescribing Information, Jan. 2015, Janssen Pharmaceuticals, Inc.
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005;353:487-497.
Kumbhani DJ, Steg PG, Cannon CP, et al. Adherence to Secondary Prevention Medications and Four-year Outcomes in Outpatients with Atherosclerosis. Am J Med.
http://dx.doi.org/10.1016/j.amjmed.2013.01.033.
Kneeland PP, Fang MC. Current issues in patient adherence and Persistence: Focus on Anticoagulants for the Treatment and Prevention of Thromboembolism. Pat Pref Adher 2010;4:51-60.
Ferguson C, Inglis SC, Newton PJ, et al. Atrial Fibrillation and Thromboprophylaxis in Heart Failure: The Need for Patient-Centered Approaches to Address Adherence. Vascular Health and Risk Management 2013;9:3-11.

ACE-Inhibitors (ACE-I), Angiotensin II Receptor Blockers (ARB) and Renin Inhibitor PA Form

health information designs

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

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for an ACE-I, ARB, Renin Inhibitor, or any combination not listed below must meet the following criteria:

*Note:
- **ACE-I: Captopril, enalapril, ramipril, lisinopril, trandolapril, quinapril, benazepril, and fosinopril and their hydrochlorothiazide containing combinations do not require a prior authorization. Epaned does not require a PA for patients less than 7 years of age.**
- **Angiotensin II receptor antagonists: Losartan does not require a prior authorization.**
- **Renin Inhibitor: Aliskiren and combination products require a prior authorization.**

Part I: TO BE COMPLETED BY PRESCRIBER

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:	**Diagnosis for this request:**		

Qualifications for coverage:

□ Failed therapy	Start Date	End Date	Dose	Frequency

□ *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 recipient.*

Prescriber (or Staff) / Pharmacy Signature	Date

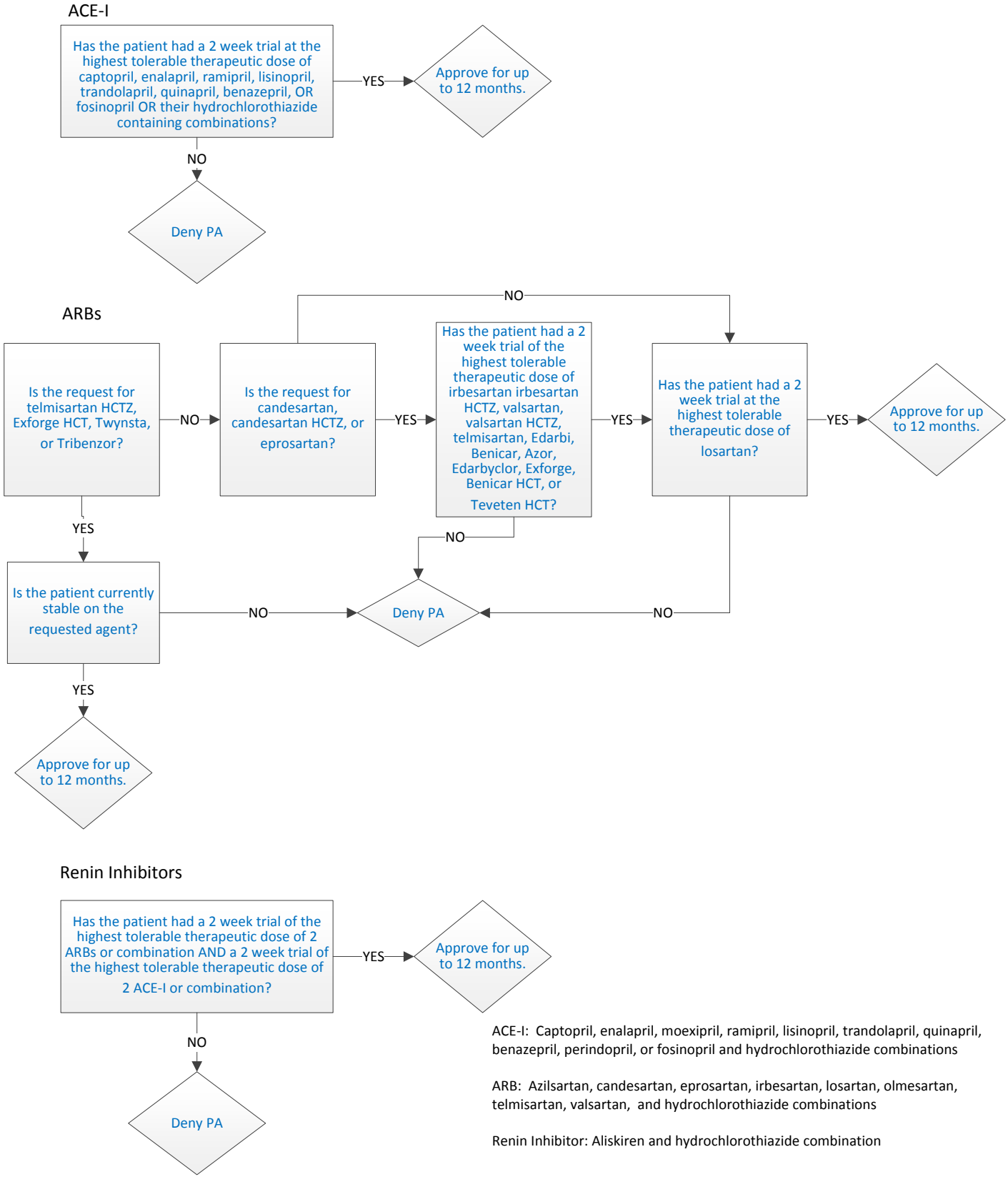
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
ACE-Is, ARBs, and Renin Inhibitor
Authorization Criteria Algorithm

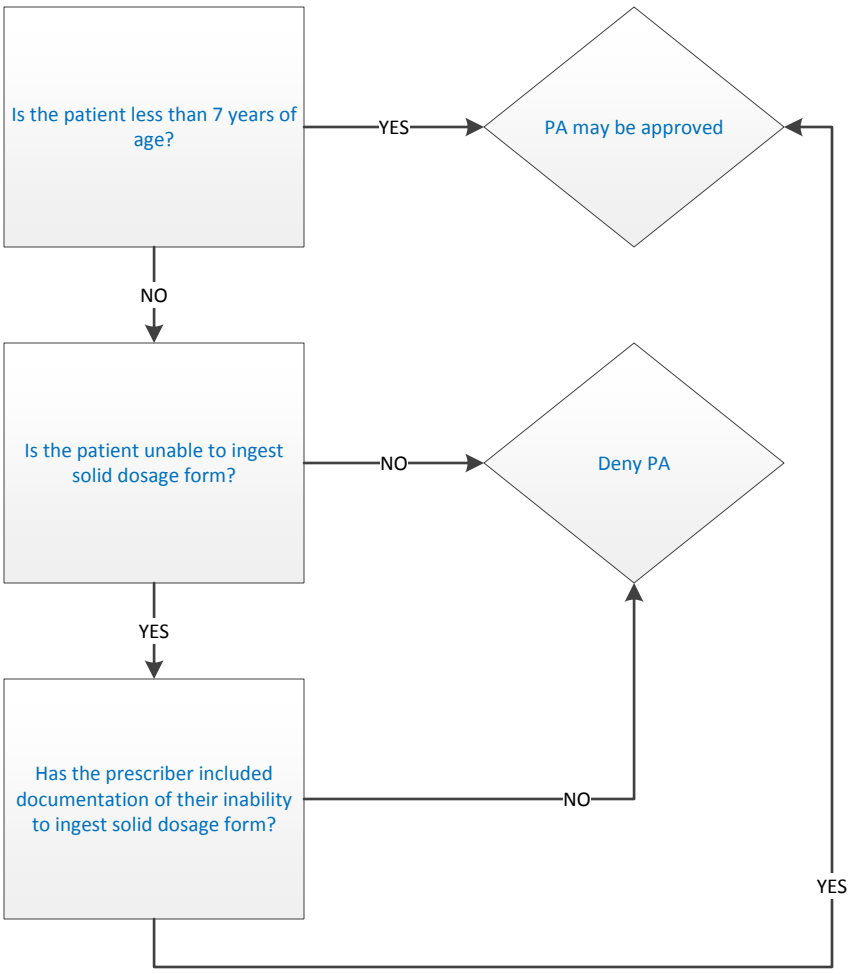


ACE-I: Captopril, enalapril, moexipril, ramipril, lisinopril, trandolapril, quinapril, benazepril, perindopril, or fosinopril and hydrochlorothiazide combinations

ARB: Azilsartan, candesartan, eprosartan, irbesartan, losartan, olmesartan, telmisartan, valsartan, and hydrochlorothiazide combinations

Renin Inhibitor: Aliskiren and hydrochlorothiazide combination

North Dakota Department of Human Services
Epaned Authorization Algorithm



ACTINIC KERATOSIS PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Solaraze, Zyclara, or Picato must first try imiquimod.

- ***Imiquimod does not require prior authorization***

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ ZYCLARA □ SOLARAZE □ PICATO	**Diagnosis for this Request:**		
Prescriber (or Staff) / Pharmacy Signature		Date	

Part II: TO BE COMPLETED BY PHARMACY

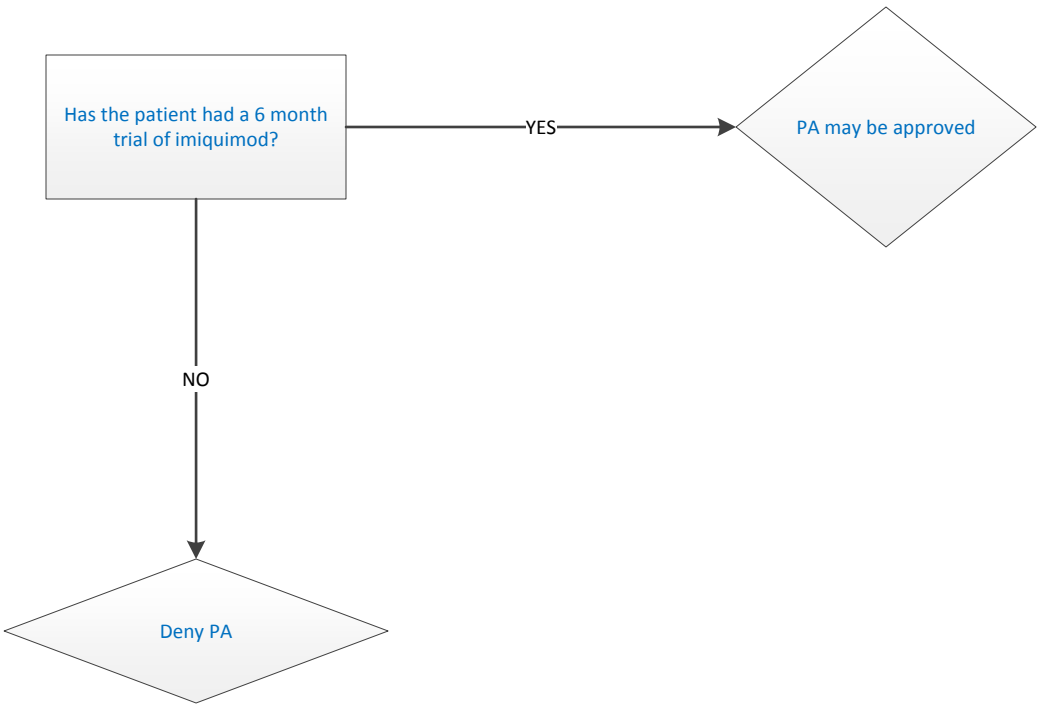
PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

Revised: 06/04/2015

North Dakota Department of Human Services
Actinic Keratosis Authorization Algorithm



ALTEPLASE
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Alteplase must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Alteplase is indicated for restoration of function to central venous access devices as assessed by the ability to withdraw blood.**

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ ALTEPLASE	**Diagnosis for this Request:**		
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature		Date	

Part II: TO BE COMPLETED BY PHARMACY

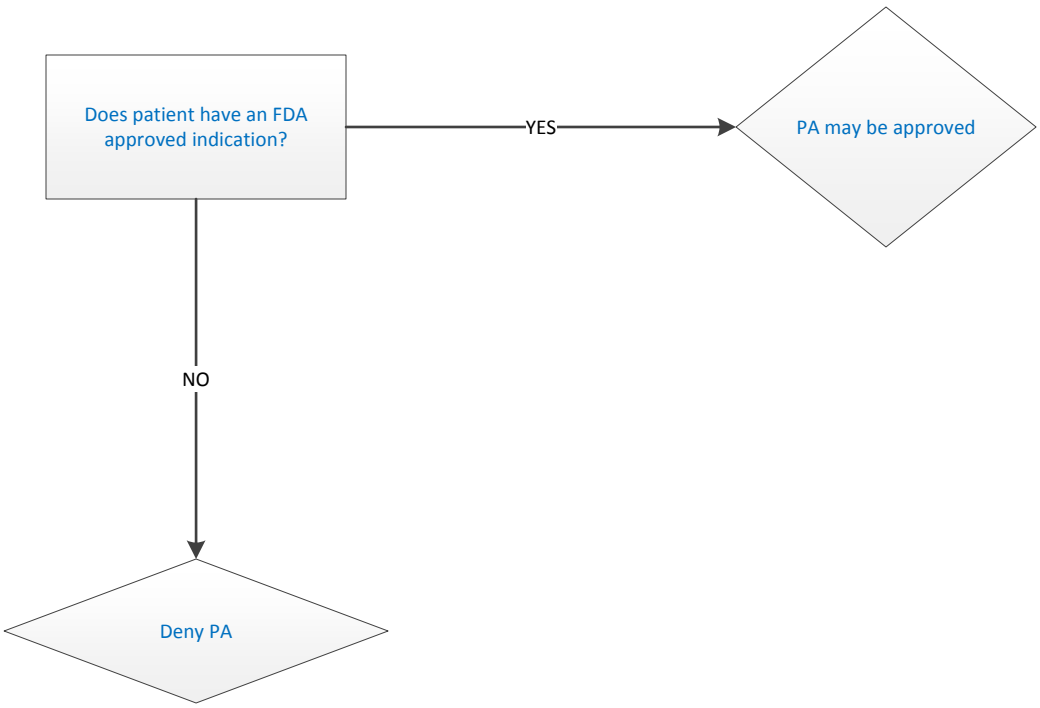
PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

Revised: 06/04/2015

North Dakota Department of Human Services
Alteplase Authorization Algorithm



AMPYRA PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Ampyra must meet the following criteria:

- **Patient must be 18 years or older.**
- **Patient must have a specialist (neurologist or physiatrist) involved in therapy.**
- **Patient must have a confirmed diagnosis of multiple sclerosis.**
- **Patient must not have a history of seizures**
- **Patient's CrCl (creatinine clearance) must be greater than 50mL/min**
- **Renewal PA requests must include patient's current T25FW.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ AMPYRA	**FDA approved indication for this request:**		
Has patient experienced any acute exacerbations within the last 60 days?	□ YES	□ NO	
Does the patient have a CrCL greater than 50mL/min?	□ YES	□ NO	
Does the patient have a history of seizures?	□ YES	□ NO	
What is the patient's baseline Timed 25-foot Walk (T25FW)?	**If this is a renewal PA request, please include patient's current T25FW:**		
Prescriber (or Staff) / Pharmacy Signature		Date	

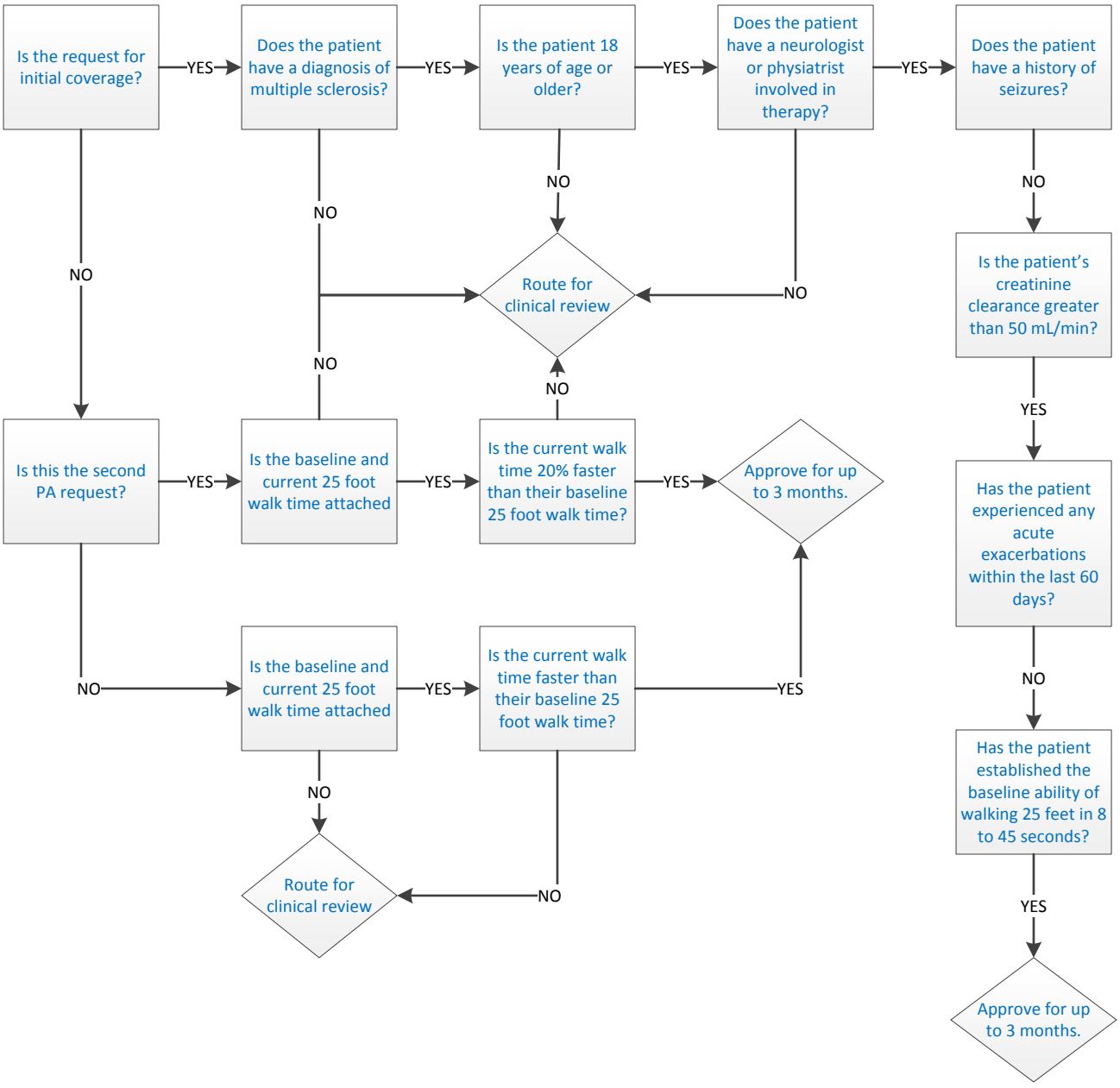
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Ampyra Authorization Algorithm



health information designs

AMRIX PA 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 patients try and fail generic cyclobenzaprine.

*__Note:__

- **Cyclobenzaprine does not require PA**
- **Patient must fail therapy on generic cyclobenzaprine before a PA will be considered for Amrix.**

Part I: TO BE COMPLETED BY PRESCRIBER

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	
PRESCRIBER NAME:	PRESCRIBER NPI:
Address:	Phone: ( )
City:	FAX: ( )
State: Zip:	

REQUESTED DRUG:	**Requested Dosage:** (must be completed)

Qualifications for coverage:

❑ Failed cyclobenzaprine therapy

Start Date:
End Date:

Dose:
Frequency:

Diagnosis:

□ *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 recipient.*

Prescriber (or Staff) / Pharmacy Signature: Date:

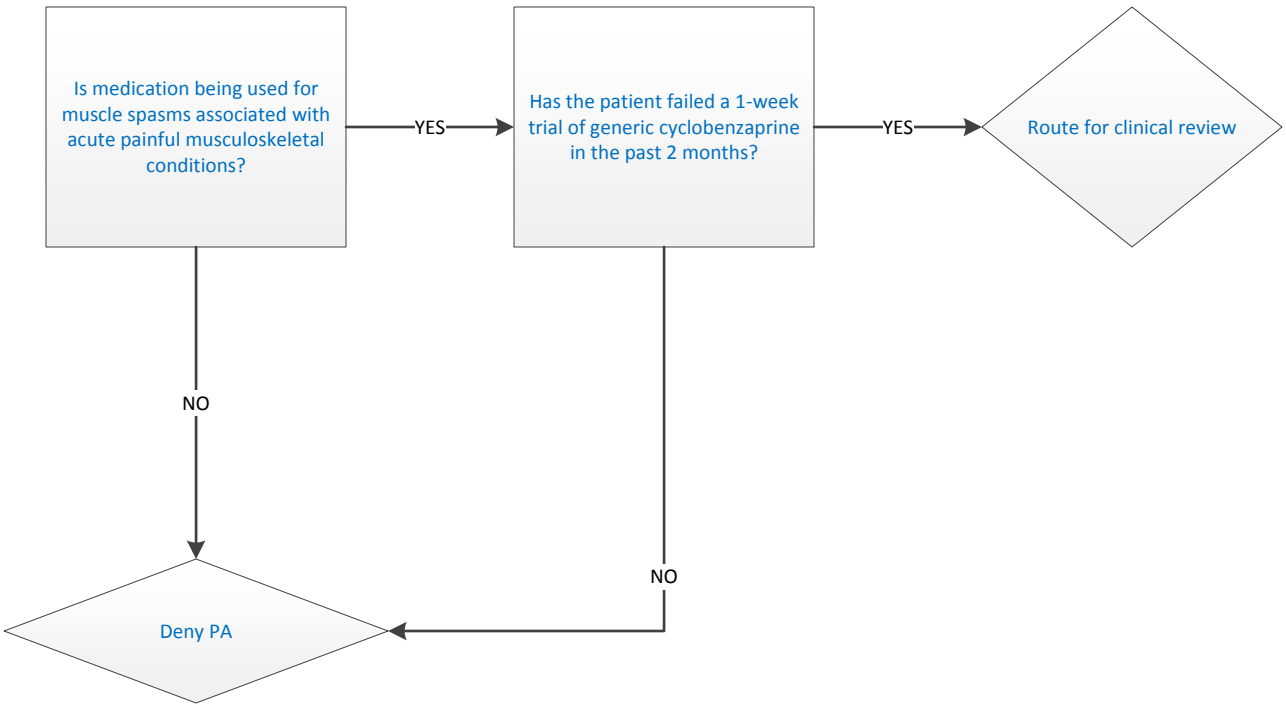
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Part III: FOR OFFICIAL USE ONLY

Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	

North Dakota Department of Human Services
Amrix Authorization Algorithm



health information designs

ANTIHISTAMINE PA 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 patients receiving antihistamines must use loratadine (Claritin generic) and cetirizine (Zyrtec generic) as step therapy.

***Note:**

- ***Loratadine OTC and cetirizine OTC (or prescription generic) may be prescribed WITHOUT prior authorization.***
- ***Loratadine OTC and cetirizine OTC are covered by Medicaid when prescribed by a physician.***
- ***Patients must use loratadine or cetirizine for a minimum of 14 days for the trial to be considered a failure. Patient preference does not constitute a failure.***

Part I: TO BE COMPLETED BY PRESCRIBER

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	
PRESCRIBER NAME:	PRESCRIBER NPI:
Address:	Phone: ( )
City:	FAX: ( )
State: Zip:	
REQUESTED DRUG:	**Requested Dosage:** (must be completed) **Diagnosis for this request:**

Qualifications for coverage:

□ Failed loratadine or cetirizine (include which agent failed)_____	Start Date:	End Date:

□ *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 recipient.*

Prescriber (or Staff) / Pharmacy Signature: Date:

Part II: TO BE COMPLETED BY PHARMACY

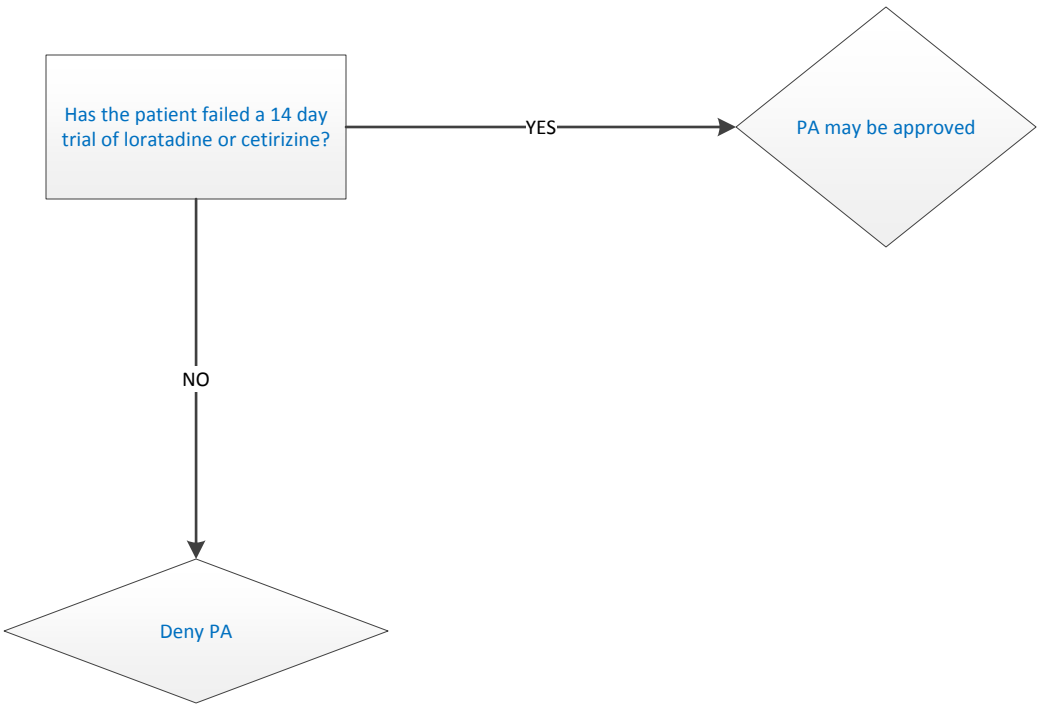
PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Part III: FOR OFFICIAL USE ONLY

Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	

Revised: 06/04/2015

North Dakota Department of Human Services
Antihistamines Authorization Algorithm



health information designs

Asacol HD Prior Authorization

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 patients receiving a new prescription for Asacol HD must try and fail a 30 day trial of Delzicol.
Note:

- ***Asacol HD is FDA approved to treat flares in patients with moderately active ulcerative colitis.***

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ **Asacol HD**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED THERAPY START DATE: END DATE:	DOSE: FREQUENCY:		
Prescriber (or Staff) / Pharmacy Signature		Date	

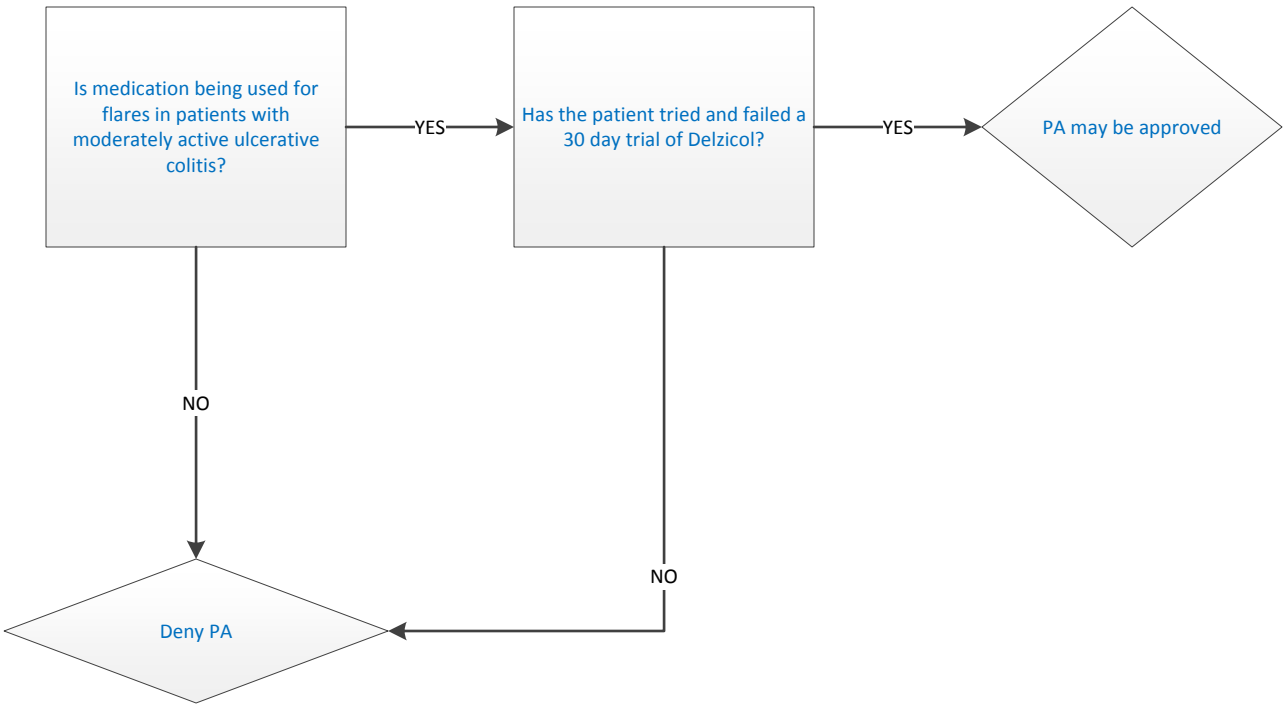
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Asacol HD Authorization Algorithm



health information designs

Aubagio Prior Authorization

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 patients who are prescribed Aubagio must follow these guidelines:

- ***Patient must have a confirmed diagnosis of a relapsing form of multiple sclerosis.***
- ***Patient must have a neurologist involved in therapy.***
- ***Obtain transaminase and bilirubin levels within 6 months before initiation of Aubagio and monitor ALT levels at least monthly for 6 months.***
- ***Aubagio is contraindicated in pregnant women or women of childbearing potential who are not using reliable contraception.***
- ***Patient must try a 3 month trial of Copaxone.***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Neurologist involved in therapy:		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Qualifications for coverage:			
Requested Drug and Dosage: □ **Aubagio**	**Diagnosis for this request:**		
□ **Failed Copaxone therapy** **Start Date:** **End Date:** **Dose:** **Frequency:** **Documented intolerance/FDA contraindication/hypersensitivity to Copaxone?** □ YES □ NO	**Have transaminase and bilirubin levels been obtained in the last 6 months?** □ YES □ NO **Is the patient pregnant?** □ YES □ NO **Is the patient of childbearing potential?** □ YES □ NO **Is patient using reliable contraception?** □ YES □ NO **Renewal PA-Has ALT been monitored monthly for the first 6 months of therapy?** □ YES □ NO **Will patient receive Coadministration with leflunomide?** □ YES □ NO		
If unable to take Copaxone please list name of beta-1 agent tried: **Start Date:** **End Date:** **Dose:** **Frequency:**			
Prescriber (or Staff) / Pharmacy Signature		Date	

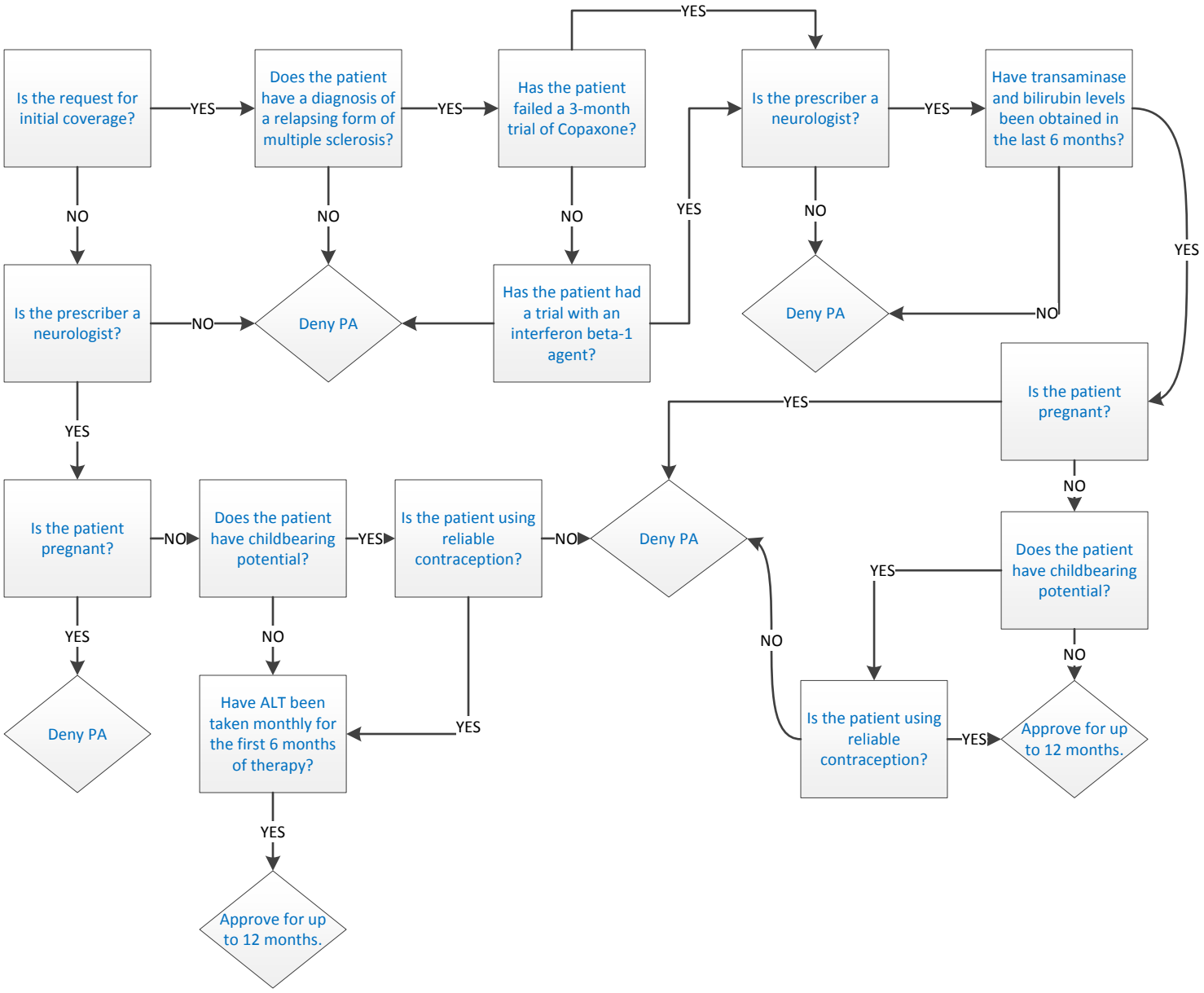
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Aubagio Authorization Algorithm



BETHKIS
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Bethkis must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Patient must be 6 years of age or older.**
- **Patient must first try TOBI or TOBI Podhaler.**

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ BETHKIS	**Diagnosis for this Request:**	**Trial:** **Start Date:** **End Date:**	
FEV1 _____	**Has the patient been colonized with Burkholderia cepacia?**		
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature		Date	

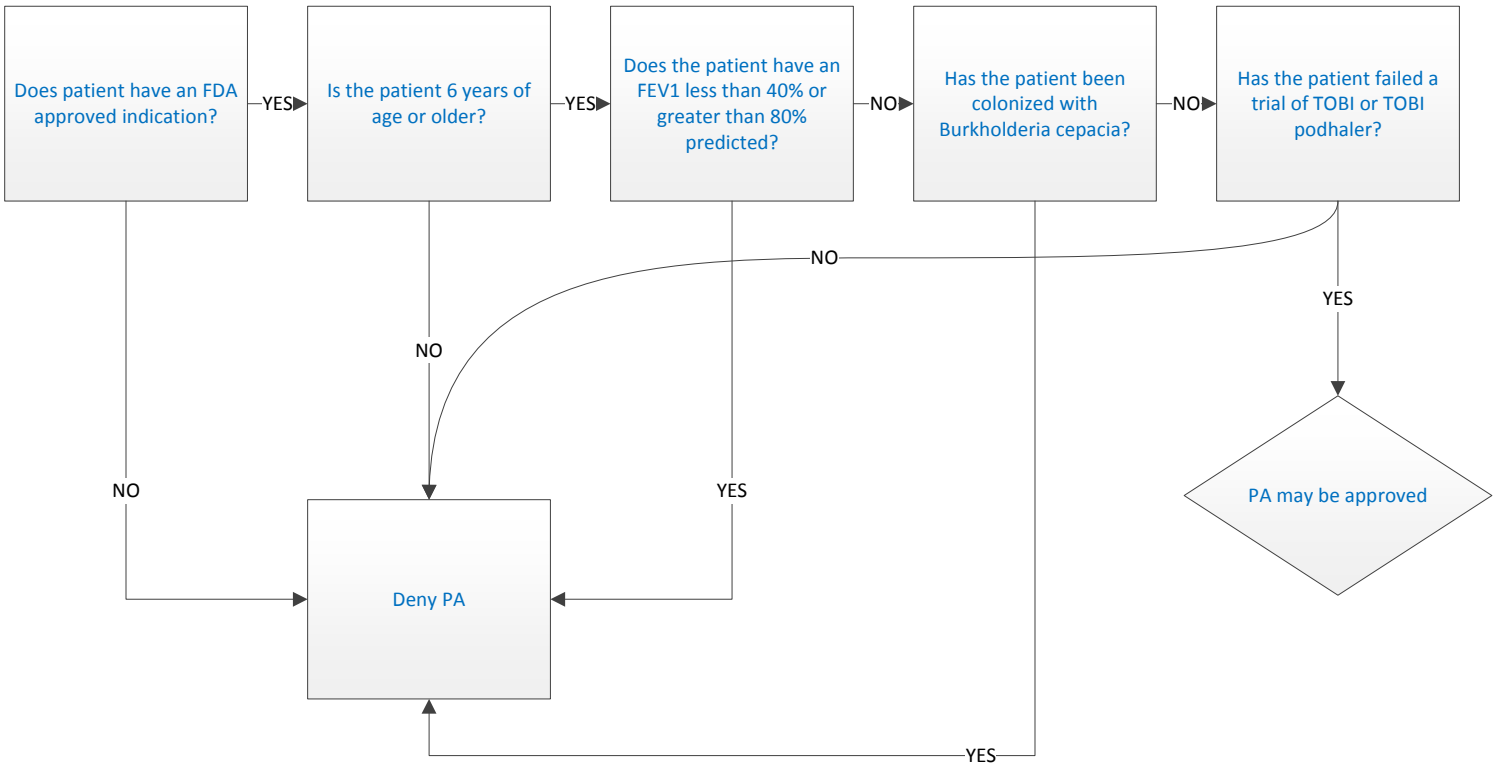
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Bethkis Authorization Algorithm



BLOOD FACTOR PRODUCTS PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 blood factor products must provide the following information:

- Visit once per year with an accredited Hemophilia Treatment Center
- Date of last appointment with treatment center
- Contact information for treatment center

Part I: TO BE COMPLETED BY PRESCRIBER

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 :	**DOSAGE:**		
Qualifications for coverage:			
TREATMENT CENTER CONTACT INFORMATION:	DATE OF LAST APPOINTMENT WITH TREATMENT CENTER: _____		
Prescriber (or Staff) / Pharmacy Signature:		Date:	

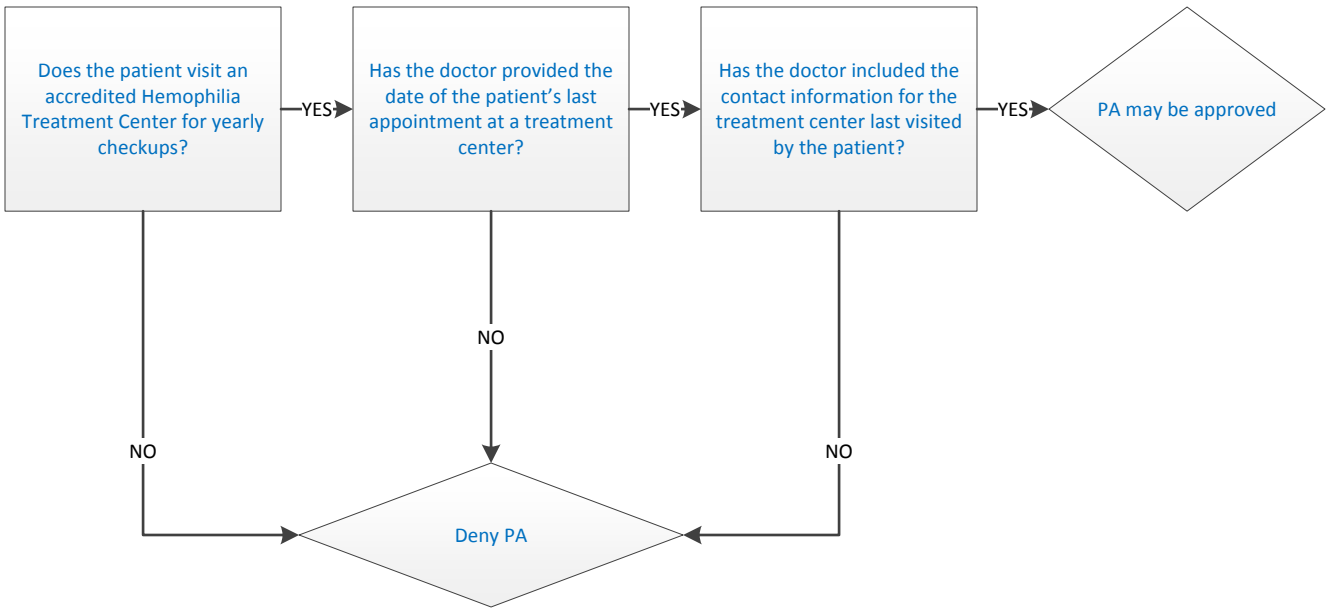
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Blood Factor Products Authorization Algorithm



health information designs

Brisdelle
Prior Authorization

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 patients receiving a new prescription for Brisdelle must meet the following criteria:

- *Patient must first try a 1-month trial of paroxetine*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

QUALIFICATIONS FOR COVERAGE:	
Requested Drug and Dosage: □ **Brisdelle**	Diagnosis for this request:
Failed Therapy:	Start Date: End Date:
Prescriber (or Staff) / Pharmacy Signature	Date

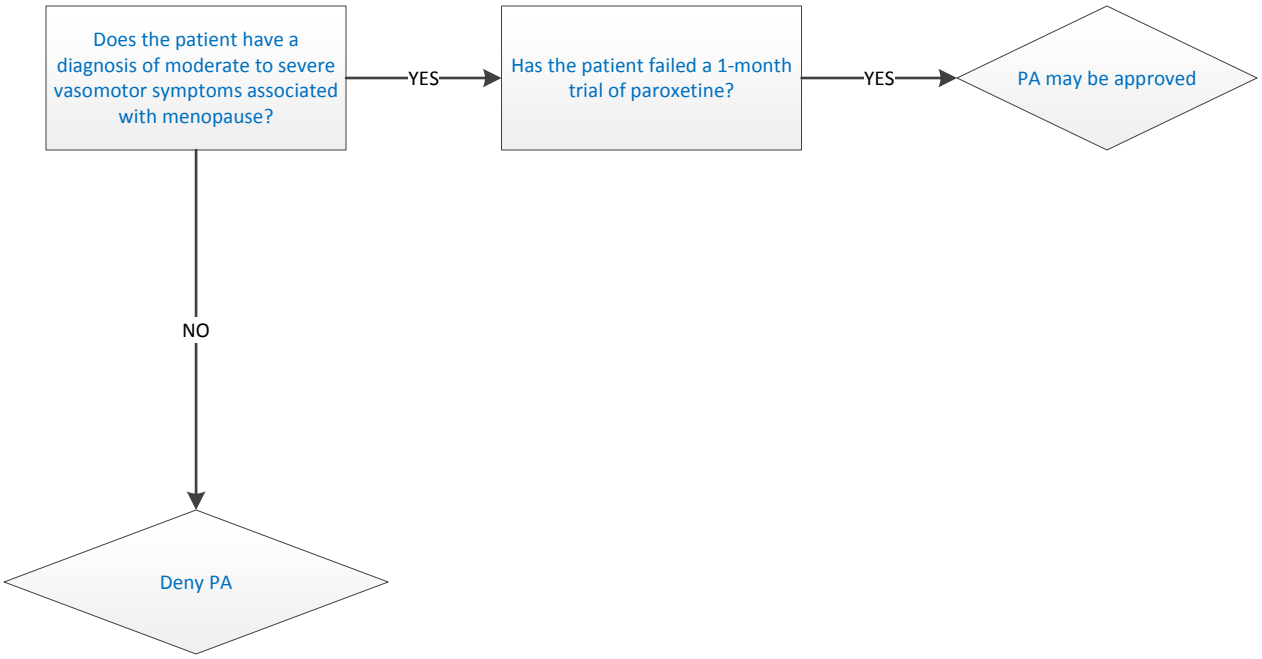
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Brisdelle Authorization Algorithm



CARISOPRODOL PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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

ND Medicaid requires that patients using carisoprodol 350mg longer than two times per year (272 tablets) must receive a prior authorization. Cyclobenzaprine, chlorzoxazone, methocarbamol and orphenadrine do not require a prior authorization.

***Note:**

- **PA will be approved if recipient is currently taking carisoprodol on a chronic basis and provider is weaning patient.**

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ CARISOPRODOL	**Diagnosis for this request:**		
Qualifications for coverage:			
□ CHRONIC CARISOPRODOL RECIPIENT BEING WEANED (PLEASE INCLUDE WEANING SCHEDULE)	Dose	Frequency	
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature	Date		

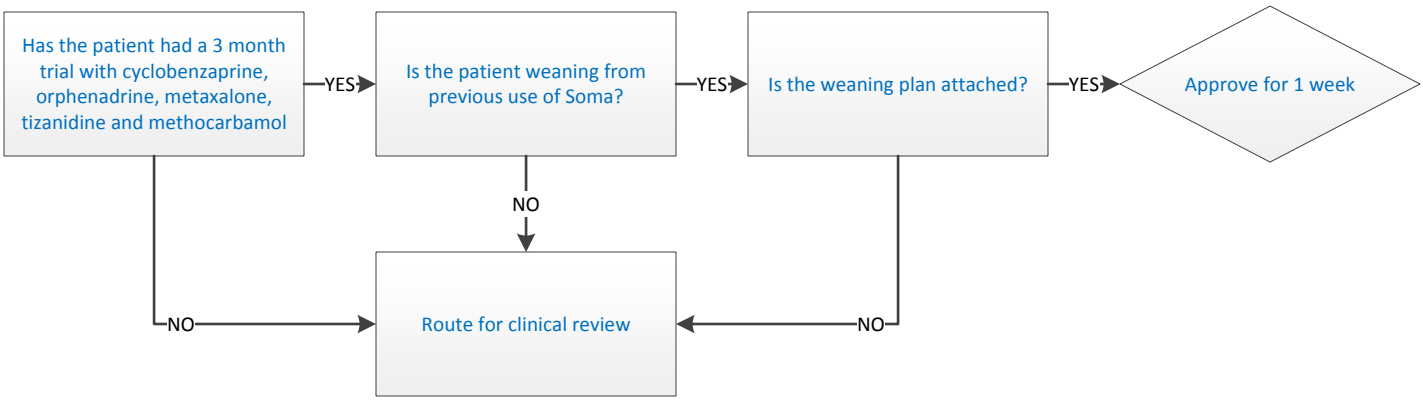
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Carisoprodol Authorization Algorithm



CAYSTON
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Cayston must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Requires step therapy. See Cayston criteria for more information.**

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ CAYSTON	**Diagnosis for this Request:**		

- **Does the patient have a FEV1 less than 25% or greater than 75% predicted?** □ YES □ NO
- **Has the patient been colonized with Burkholderia cepacia?** □ YES □ NO
- **Has the patient failed a 28-day trial of TOBI or TOBI podhaler?** □ YES □ NO

□ *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 recipient.*

Prescriber (or Staff) / Pharmacy Signature	Date

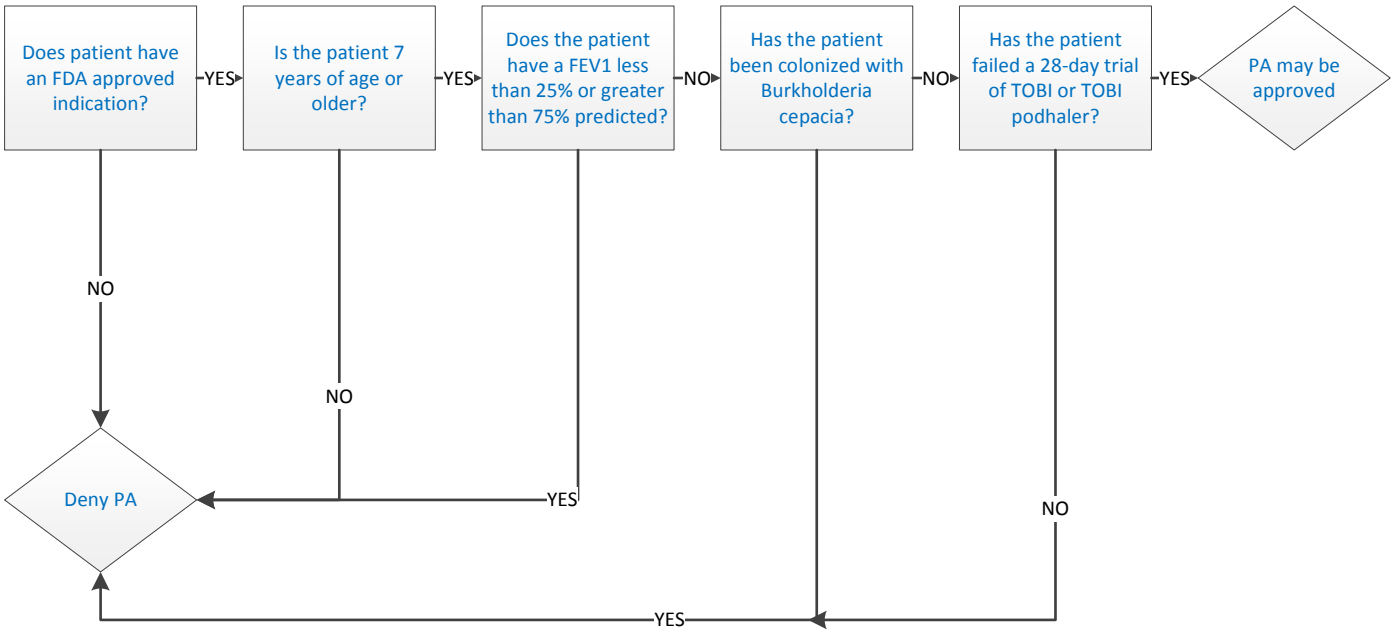
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Cayston Authorization Algorithm



CIALIS for BENIGN PROSTATIC HYPERPLASIA
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Cialis used to treat benign prostatic hyperplasia (BPH) must meet the following criteria:

- **Patient must have diagnosis of BPH**
- **Patient must try and fail all alpha blockers and 5-alpha reductase inhibitors and combinations, unless contraindicated.**

Part I: TO BE COMPLETED BY PHYSICIAN

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:	**Diagnosis for this Request:**	**Attach additional notes listing all products failed**	
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature		Date	

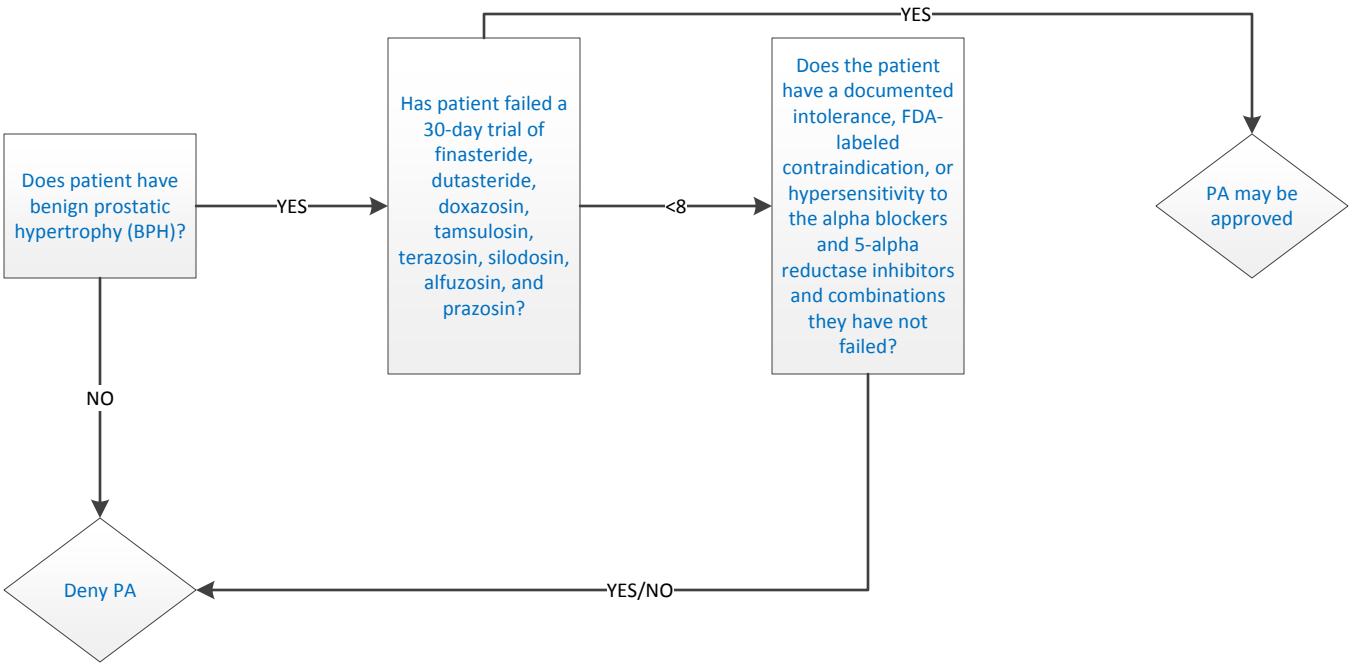
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Cialis Authorization Algorithm



COMBINATION PRODUCTS
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 a combination product that is more expensive than the individual components must meet the following criteria:

- **Patient must be currently stable on the combination product**

Part I: TO BE COMPLETED BY PHYSICIAN

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:	**Diagnosis for this Request:**		
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature		Date	

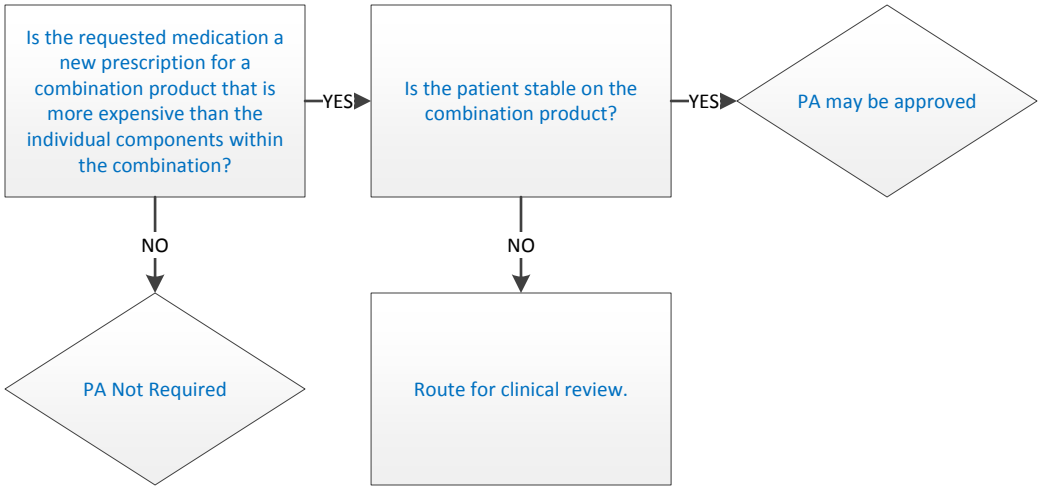
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Combination Products Authorization Algorithm



COPAXONE 40mg PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Copaxone 40mg must meet the following criteria:

- **Patient must have a confirmed diagnosis of multiple sclerosis.**
- **Requires step therapy. See Copaxone 40mg criteria for more details.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ COPAXONE 40MG	**FDA approved indication for this request:**		
• **Has patient experienced a reduction in relapse rate? (renewal requests)** □ YES □ NO			
List all failed medications:			
Prescriber (or Staff) / Pharmacy Signature	Date		

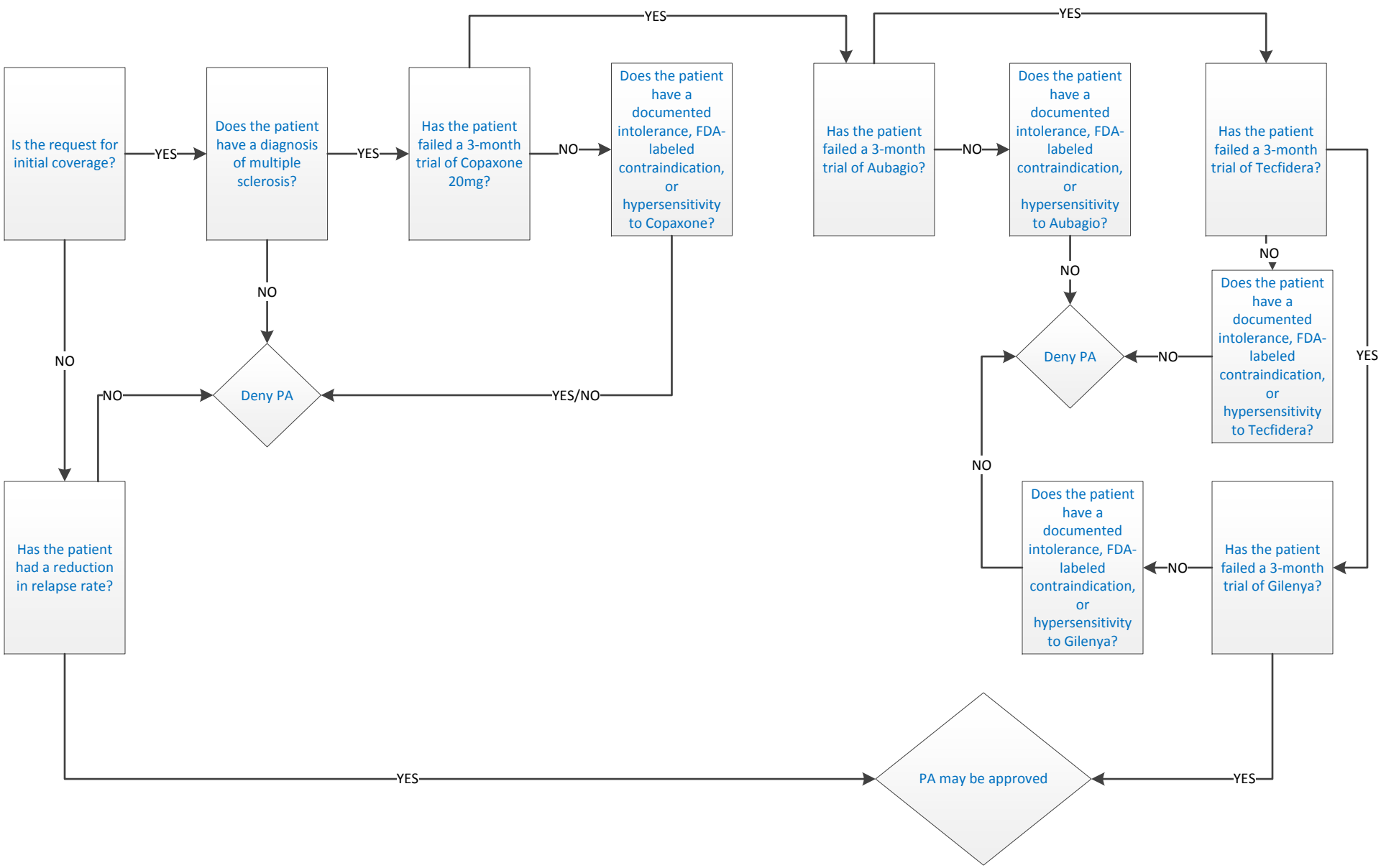
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Copaxone 40 mg Authorization Algorithm



health information designs

Agents Used to Treat COPD
Prior Authorization

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 patients receiving a new prescription for Arcapta, Brovana, Daliresp, Spiriva, Tudorza, or Anoro Ellipta must meet the following criteria:

- *Patient must have a diagnosis of COPD.*
- *Requires step therapy. See COPD criteria for more information.*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI:	Telephone Number	Fax Number	
Address	City	State	Zip Code

QUALIFICATIONS FOR COVERAGE:

Requested Drug and Dosage:	Diagnosis for this request:
□ **Arcapta** □ **Tudorza** □ **Incruse Ellipta** □ **Brovana** □ **Spiriva** □ **Striverdi Respimat** □ **Spiriva** □ **Anoro Ellipta** □ **Daliresp**	
List all failed medications:	
Prescriber (or Staff)/Pharmacy Signature	Date

Part II: TO BE COMPLETED BY PHARMACY

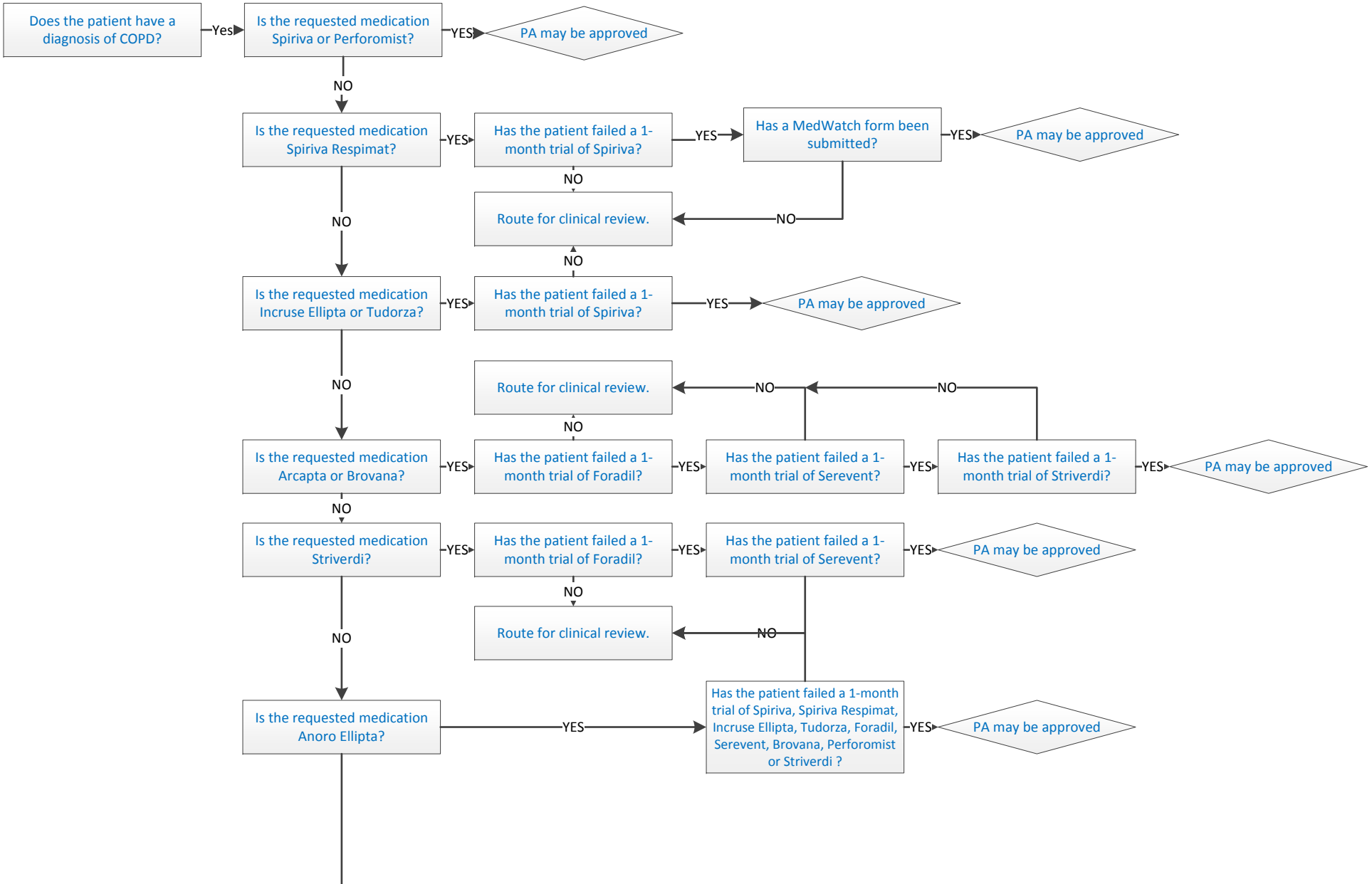
PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE NUMBER	FAX NUMBER	DRUG	NDC #

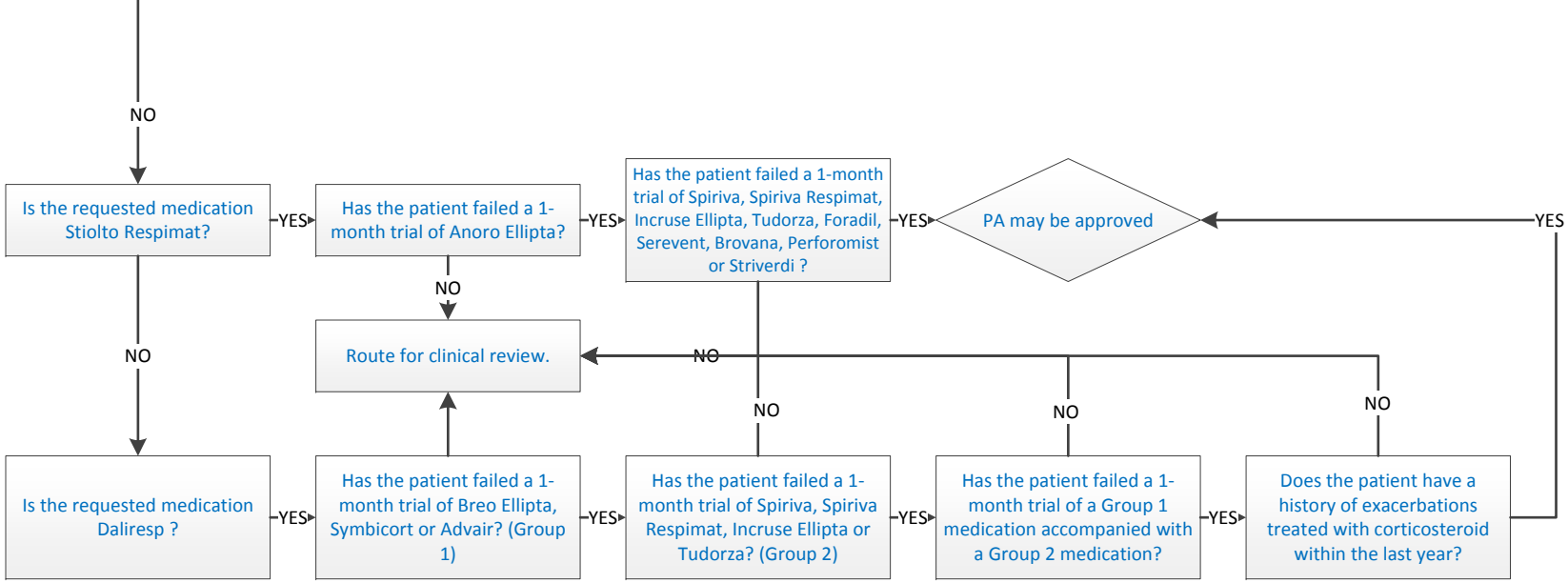
Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: /	Approved by:
Denied: (Reasons)	

Revised: 06/04/2015

North Dakota Department of Human Services
COPD Authorization Algorithm




NO
Is the requested medication Stiolto Respimat?
YES
Has the patient failed a 1-month trial of Anoro Ellipta?
YES
Has the patient failed a 1-month trial of Spiriva, Spiriva Respimat, Incruse Ellipta, Tudorza, Foradil, Serevent, Brovana, Perforomist or Striverdi ?
YES
PA may be approved
YES
NO
Route for clinical review.
NO
NO
NO
NO
Is the requested medication Daliresp ?
YES
Has the patient failed a 1-month trial of Breo Ellipta, Symbicort or Advair? (Group 1)
YES
Has the patient failed a 1-month trial of Spiriva, Spiriva Respimat, Incruse Ellipta or Tudorza? (Group 2)
YES
Has the patient failed a 1-month trial of a Group 1 medication accompanied with a Group 2 medication?
YES
Does the patient have a history of exacerbations treated with corticosteroid within the last year?

health information designs

DAKLINZA PA 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 patients receiving a new prescription for Daklinza must meet the following criteria:

- Patient must be ≥ 18 years old.
- Must have a diagnosis of chronic hepatitis C (genotype 3).
- Liver biopsy showing fibrosis corresponding to a Metavir score of greater than or equal to 2 or Ishak score of greater than or equal to 3 or other accepted test demonstrating liver fibrosis.
- Must be prescribed by or in consultation with a hepatologist, gastroenterologist, or infectious disease specialist.
- Documentation showing that patient is drug and alcohol free for the past 12 months

The concomitant use of Daklinza and strong inducers of CYP3A is contraindicated.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug	**Documented liver fibrosis:**	**Diagnosis for this request:**	**Patient is drug and alcohol free for past 12 months:**
□ **Daklinza** Dosage: _____	**Does the patient have cirrhosis?** □ YES □ NO	**Genotype:**	□ YES □ NO *PROVIDE DOCUMENTATION **Sofosbuvir dose:**

Has the patient been previously treated for chronic hepatitis C? □ YES □ NO If yes, please indicate past treatment regimen(s), dates of treatment, and response to therapy: Has patient attested that they will continue treatment without interruption for the duration of therapy? □ YES □ NO Is the patient taking Daklinza in combination with sofosbuvir? □ YES □ NO If patient is not taking Daklinza in combination with sofosbuvir, give rationale:_____ Is the patient taking Daklinza in combination with strong inducers of CYP3A? □ YES □ NO Is the patient taking Daklinza in combination with amiodarone? □ YES □ NO Has the patient had a liver transplant? □ YES □ NO	Baseline HCV RNA: HCV RNA 4 weeks after starting therapy: Metavir Score: Ishak Score:
Prescriber (or Staff) / Pharmacy Signature	Date

Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

Hepatitis C Patient Consent Form

I, _____, have been counseled by my healthcare provider on the following:

- ☐ I agree to complete the entire course of treatment and have laboratory tests before starting, during, and after completing treatment as ordered by my healthcare provider.
- ☐ I understand that for the medication to work, it is important that I take my medication each day for the entire course of treatment.
- ☐ I understand the importance to not drink alcohol or use illicit drugs during and after my treatment for Hepatitis C.
- ☐ I understand how to avoid being re-infected with Hepatitis C during and after my treatment.
- ☐ (Females) I understand that these drugs are harmful to babies. I will use two methods to avoid getting pregnant. I understand that this medication may cause serious birth defects to an unborn child for up to 6 months after I have completed my treatment.
- ☐ (Males) I understand that while I am taking the medication, I must avoid getting my partner pregnant. If my partner becomes pregnant, the baby may have serious birth defects. My partner and I will prevent pregnancy using two forms of birth control for up to 6 months after my treatment is complete. If I have a committed partner, I have discussed these risks with her.

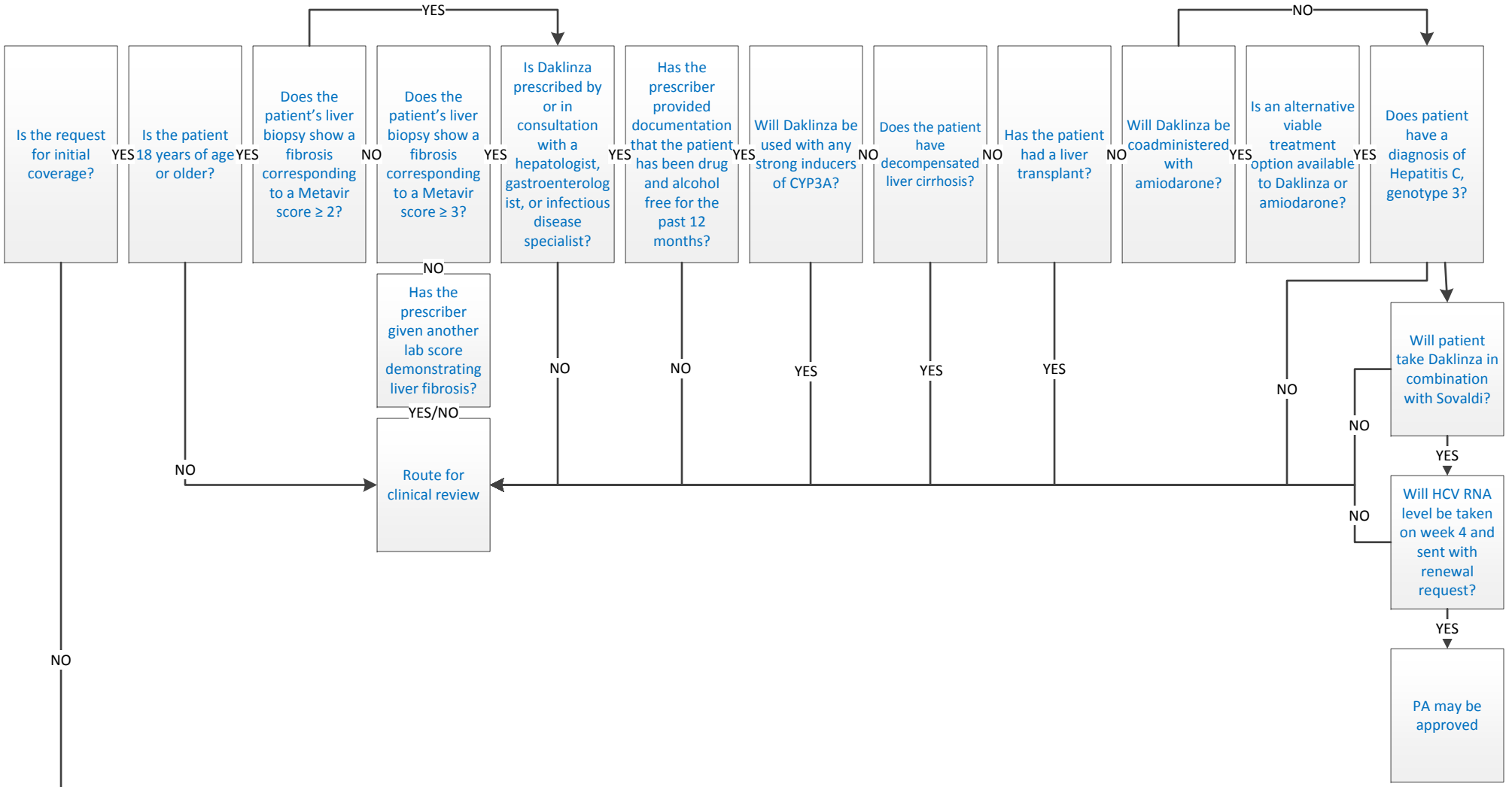
Patient Signature _____ Date __/__/____

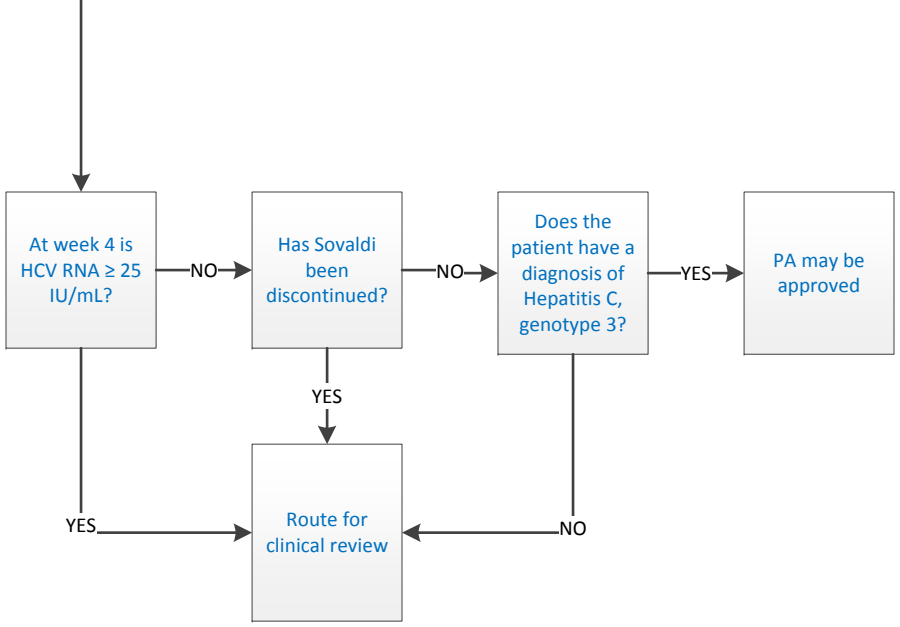
Pharmacy or Prescriber Representative:

Signature _____ Date __/__/____

By signature, the pharmacy or prescriber representative confirms the contract has been reviewed with the patient.

North Dakota Department of Human Services
Daklinza Authorization Algorithm




At week 4 is HCV RNA ≥ 25 IU/mL?
NO
Has Sovaldi been discontinued?
NO
Does the patient have a diagnosis of Hepatitis C, genotype 3?
YES
PA may be approved
YES
YES
Route for clinical review
NO

health information designs

Prior Authorization Vendor for ND Medicaid

DISPENSE AS WRITTEN PA FORM

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

North Dakota Medicaid requires that patients receiving a brand name drug, when there is a generic equivalent available, must first try and fail the generic product for one of the following reasons.

- **The generic product was not effective (attach MedWatch form)**
- **There was an adverse reaction with the generic product (attach MedWatch form)**
- **DAW not allowed for drugs with an authorized generic available.**

Part I: TO BE COMPLETED BY PRESCRIBER

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:	**DOSAGE:**	**Diagnosis for this request:**		

QUALIFICATIONS FOR COVERAGE: □ FAILED GENERIC EQUIVALENT**(ATTACH FDA MEDWATCH FORM)**	**Start Date**	**End Date**	**Dose**	**Frequency**

ADVERSE REACTION TO GENERIC EQUIVALENT (ATTACH FDA MEDWATCH FORM)

□ *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 recipient.*

Prescriber (or Staff) / Pharmacy Signature	Date

Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

DEXPAK/ZEMAPAK PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 DexPak or Zema-Pak must meet the following criteria:

- **Patient must first try and fail with dexamethasone**

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ DEXPAK □ ZEMA-PAK	**Diagnosis for this Request:**		
Failed Therapy (dose and frequency): □ DEXAMETHASONE	**Start Date:** **End Date:**		
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature		Date	

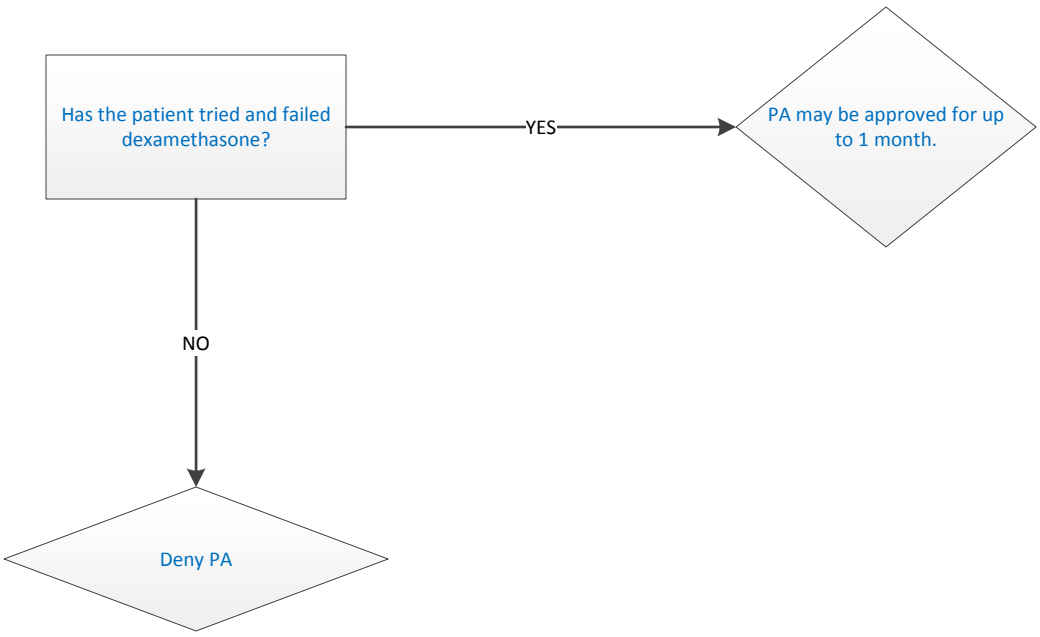
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Dexpak Authorization Algorithm



health information designs

Diabetic Test Strip Prior Authorization

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 patients receiving a new prescription for diabetic test strips must use Freestyle brand.
Note:

- ***Freestyle test strips do not require a PA.***

Part I: TO BE COMPLETED BY PHYSICIAN

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:	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Patient has an insulin pump			
Prescriber (or Staff) / Pharmacy Signature		Date	

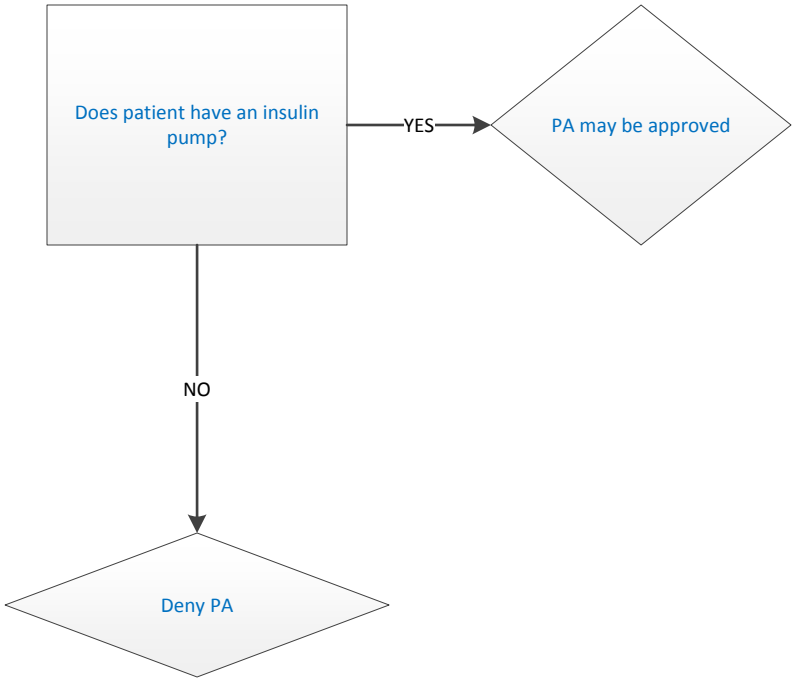
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Diabetic Test Strips Authorization Algorithm



health information designs

Diclegis
Prior Authorization

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 patients receiving a new prescription for Diclegis must meet the following criteria:

- *Patient must have diagnosis of nausea and vomiting of pregnancy*
- *Patient must first try ondansetron*
- *Requires step therapy. See Diclegis criteria for more information.*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

QUALIFICATIONS FOR COVERAGE:

Requested Drug and Dosage: □ **Diclegis**	Diagnosis for this request:
Failed Therapy:	Start Date: End Date:
Prescriber (or Staff) / Pharmacy Signature	Date

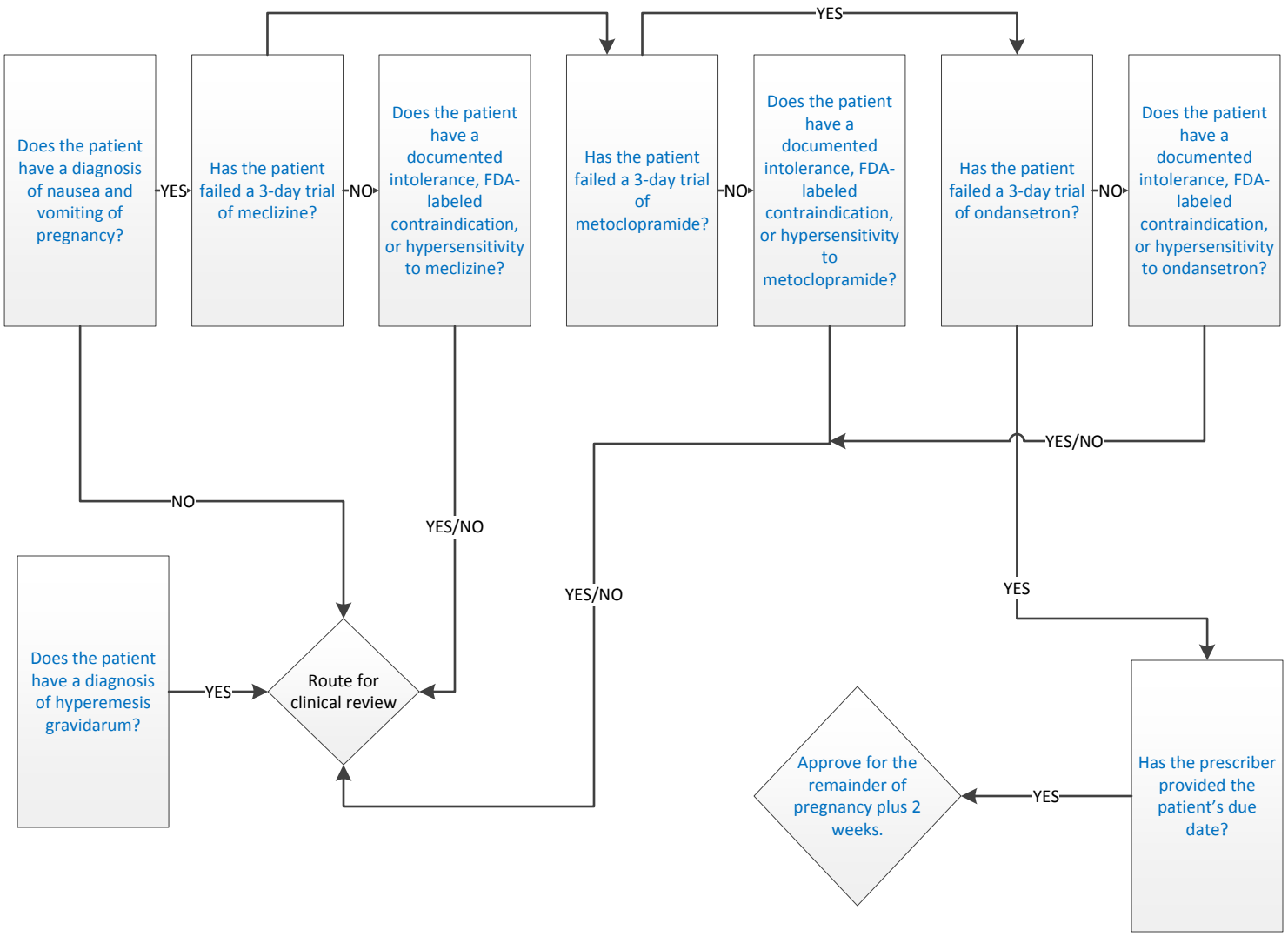
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Diclegis Authorization Algorithm



DIFICID PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Dificid must meet the following criteria:

- **Patient must have diagnosis of *Clostridium difficile*-associated diarrhea (CDAD)**
- **Patient must be ≥ 18 years of age**
- **Patient must have been treated per the current guidelines and failed**
- **Compounded oral vancomycin is covered without prior authorization**
- **Metronidazole is covered without prior authorization**
- **Requires step therapy. See Dificid criteria for more information.**

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ DIFICID	**Diagnosis for this Request:**	**Failed therapy:** **Start Date:** **End Date:**
□ *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 recipient.*		
Prescriber (or Staff) / Pharmacy Signature		Date

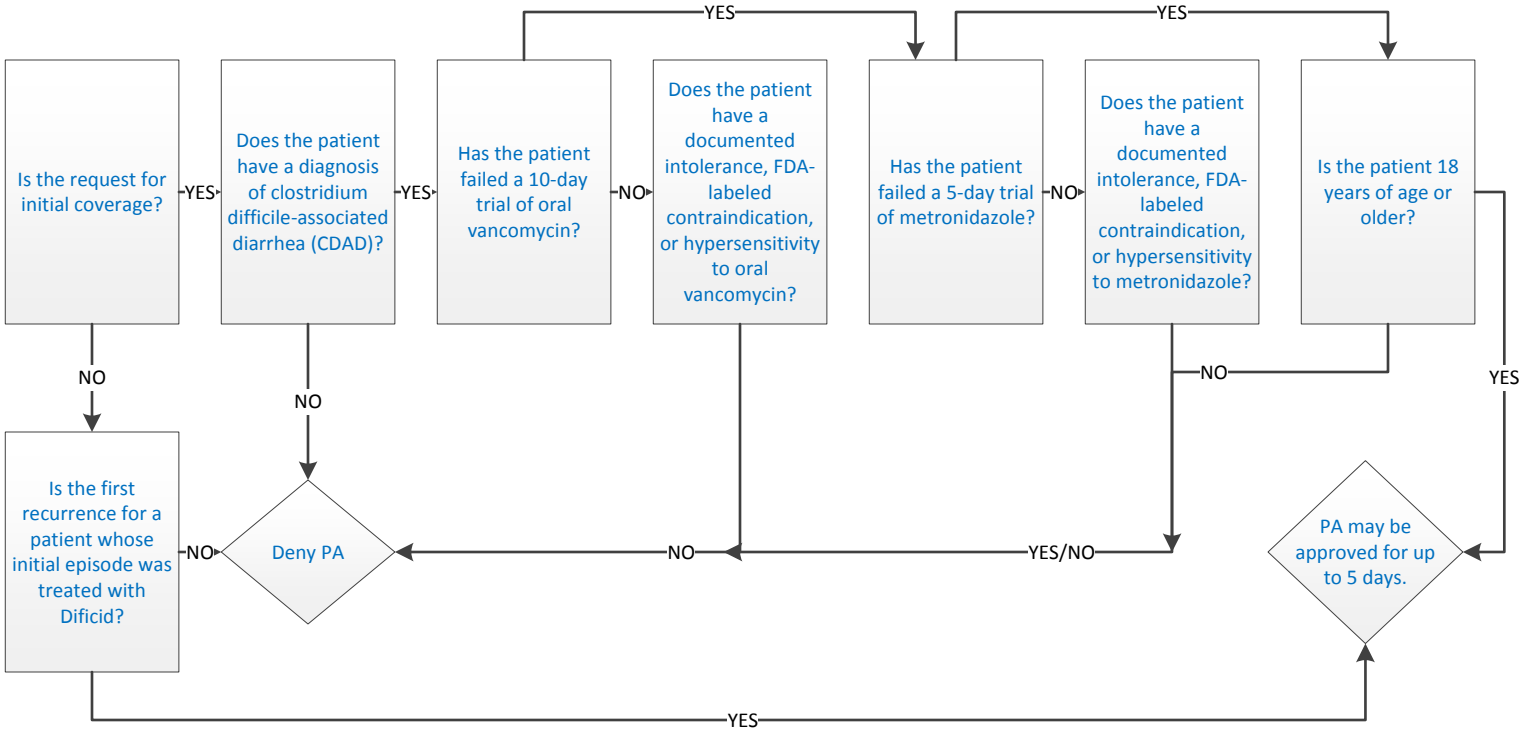
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Dificid Authorization Algorithm



ELAPRASE PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Elaprase must meet the following criteria:

- **Patient must have Hunter Syndrome.**

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ ELAPRASE	**Diagnosis for this Request:**		
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature		Date	

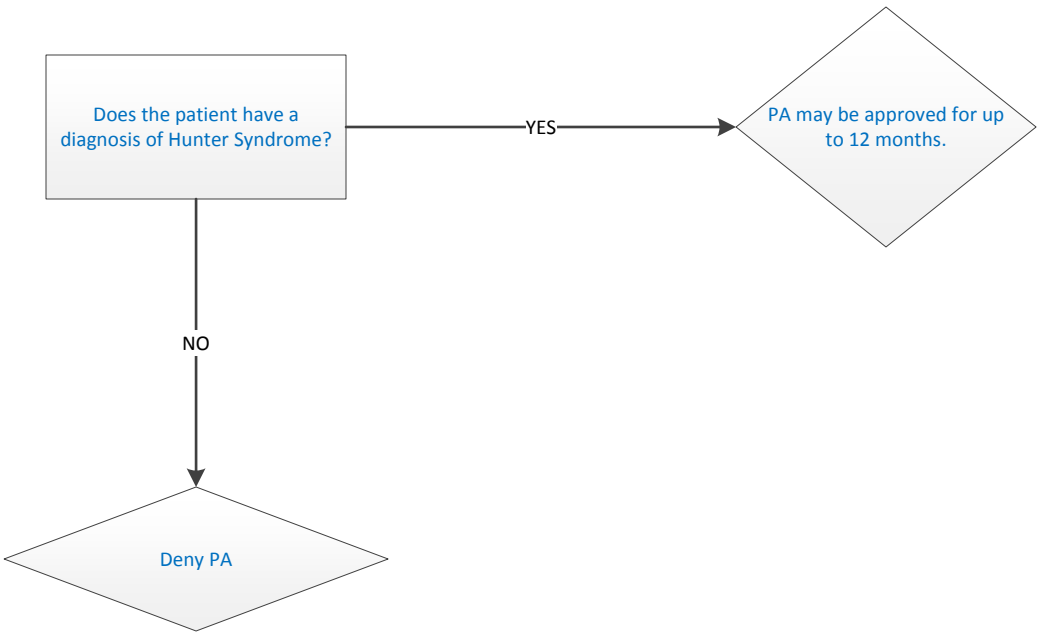
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Elaprase Authorization Algorithm



health information designs

Epinephrine Auto Injectors
Prior Authorization

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 patients receiving a new prescription for epinephrine auto injectors must use Auvi-Q as first line therapy.

- *Auvi-Q does not require a prior authorization*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI:	Telephone Number	Fax Number	
Address	City	State	Zip Code

QUALIFICATIONS FOR COVERAGE:	
Requested Drug and Dosage: □	Diagnosis for this request:
Failed Therapy:	Start Date: End Date:
Prescriber (or Staff) / Pharmacy Signature	Date

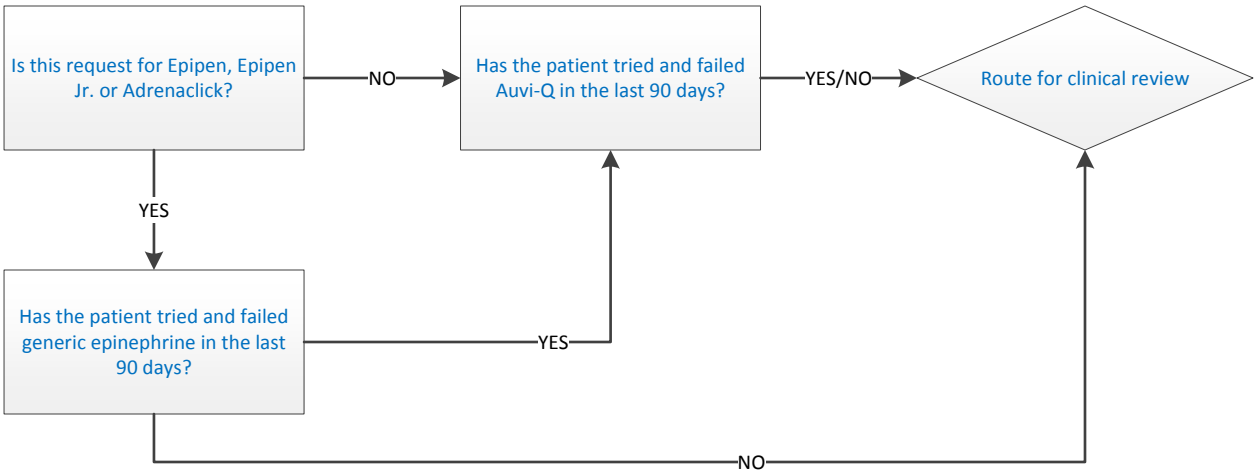
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Epinephrine Auto Injectors Authorization Algorithm



EVZIO
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Evzio must meet the following criteria:

- **Patient must have an FDA approved indication.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name and Specialty			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ EVZIO	**Diagnosis for this Request:**		

1. **Is the patient receiving addiction counseling services?** **□ YES □ NO**
   Please provide prescriber information for addiction counseling _____
2. **Reasoning behind patient's inability to take naloxone_____**
3. **Does the patient have a chronic pain issue where benefit outweighs risk of continuing treatment?** **□ YES □ NO**
4. **Has the prescriber submitted the completed Evzio overdose risk assessment form?** **□ YES □ NO**
5. **Has the patient had a previously covered dose of Evzio in the last year?** **□ YES □ NO**
6. **Was the previous dose taken by the patient?** **□ YES □ NO** **If not, did the previous dose expire?** **□ YES □ NO**
7. **Does the prescriber attest the patient is taking the opioid as prescribed?** **□ YES □ NO**
8. **Has the opioid dose been decreased?** **□ YES □ NO**
9. **Reasoning behind the opioid dose not being decreased_____**

□ *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 recipient.*

Prescriber (or Staff) / Pharmacy Signature	Date

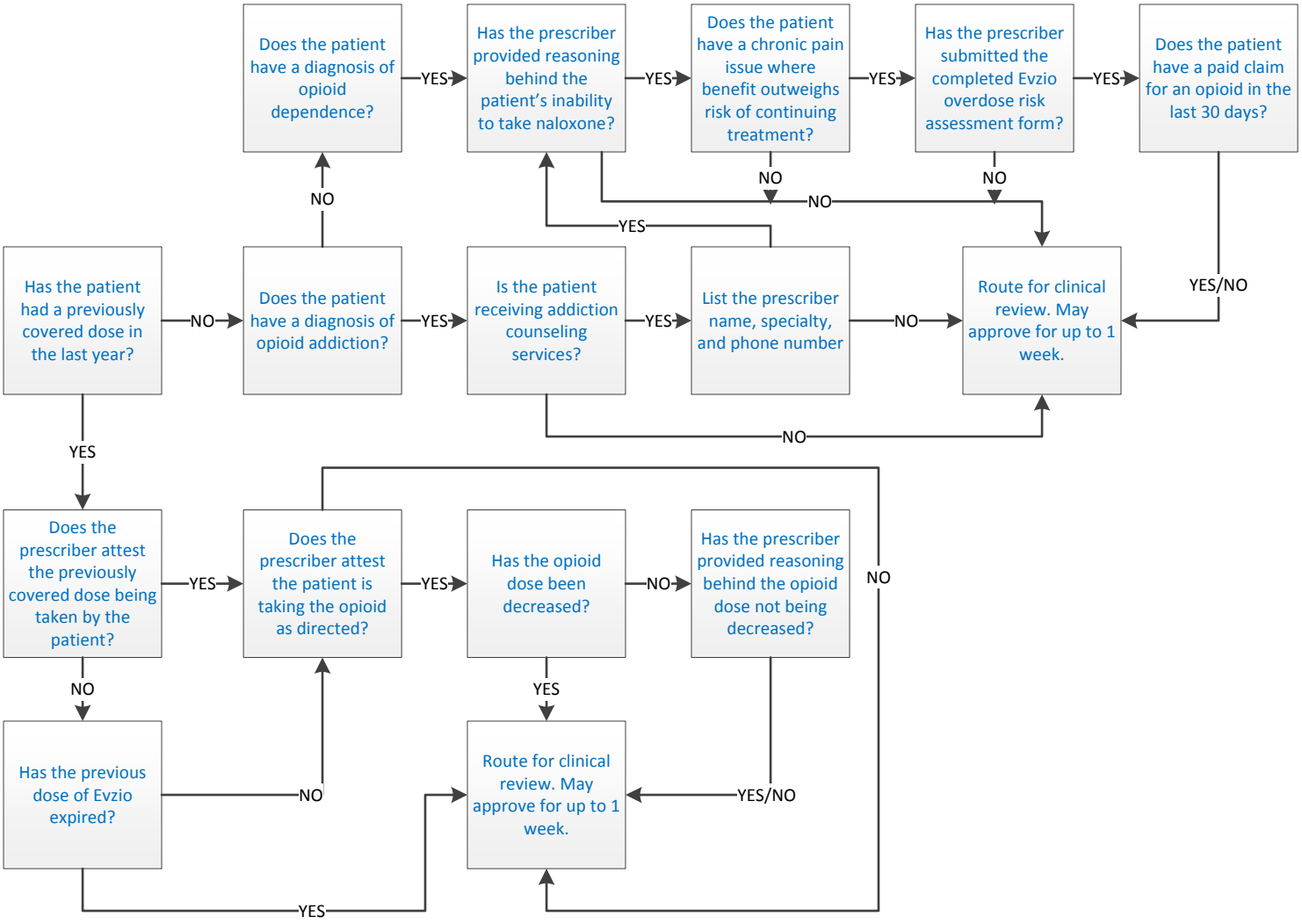
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Evzio Authorization Algorithm



health information designs

Fulyzaq
Prior Authorization

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 patients receiving a new prescription for Fulyzaq must meet the following criteria:

Note:

- **Patient must be 18 years of age or older.**
- **Patient must have non-infectious diarrhea.**
- **Patient must have HIV/AIDS and be taking anti-retroviral therapy.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI:	Telephone Number	Fax Number	
Address	City	State	Zip Code
QUALIFICATIONS FOR COVERAGE:			
Requested Drug and Dosage: □ **Fulyzaq**	Diagnosis for this request: Anti-retroviral therapy		
Prescriber (or Staff) / Pharmacy Signature	Date		

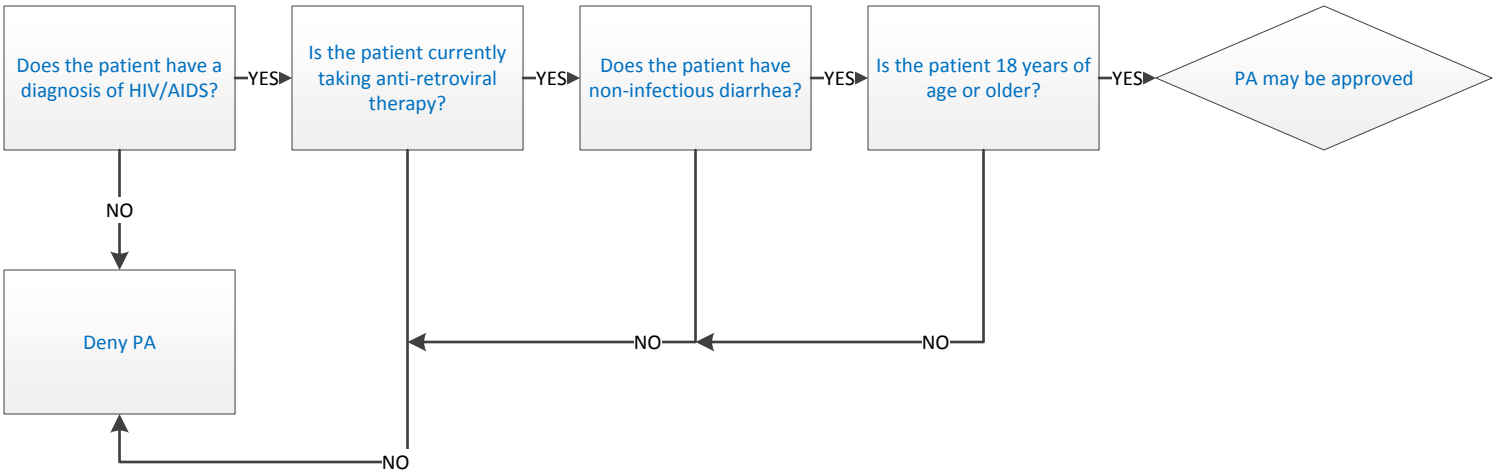
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Fulyzaq Authorization Algorithm



health information designs

Giazo
Prior Authorization

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 patients receiving a new prescription for Giazo must meet the following criteria:

- *Patient must be male.*
- *Patient must be > 18 years of age.*
- *Patient must have a diagnosis of ulcerative colitis.*
- *Patient has tried and failed balsalazide 750mg capsules.*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

QUALIFICATIONS FOR COVERAGE:

Requested Drug and Dosage:	Diagnosis for this request:
□ Giazo	
□ Failed trial of balsalazide 750mg capsules Dose:	
Prescriber (or Staff) / Pharmacy Signature	Date

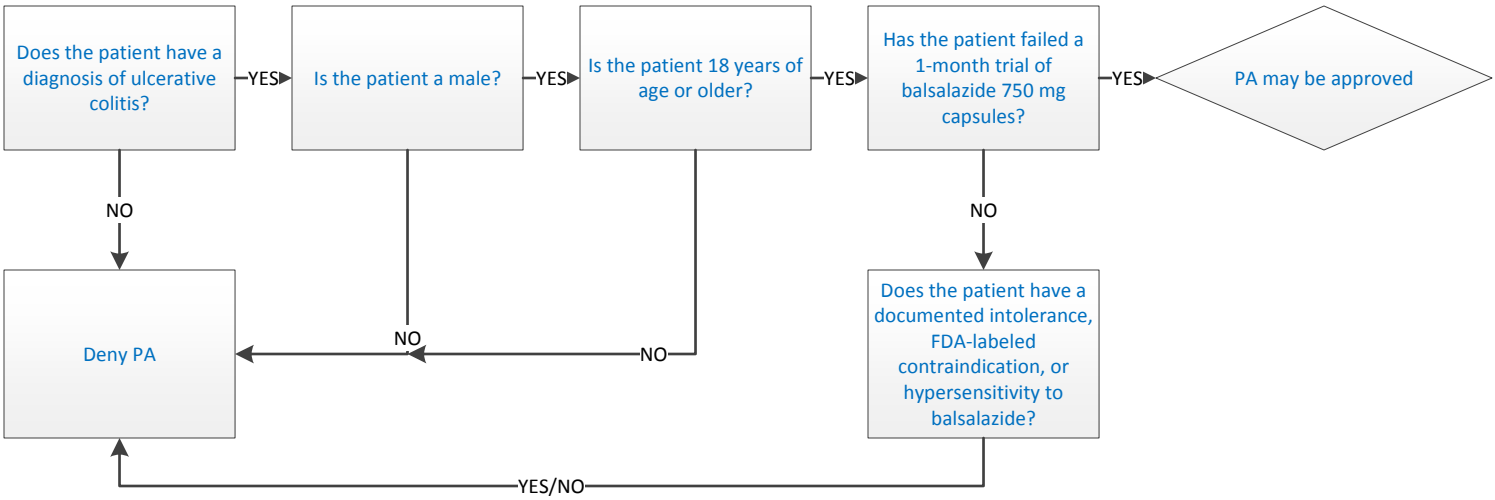
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Giazo Authorization Algorithm



health information designs

Gilenya Prior Authorization

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 patients who are prescribed Gilenya must follow these guidelines:

***Note:**

- ***Must have relapsing forms of multiple sclerosis.***
- ***Must have a current electrocardiogram (within 6 months) for patients taking anti-arrhythmics, beta-blockers, or calcium channel blockers; patients with cardiac risk factors; and patients with a slow/irregular heartbeat.***
- ***Must have a recent CBC (within 6 months).***
- ***Must have an adequate ophthalmologic evaluation at baseline and 3-4 months after treatment initiation.***
- ***Must have recent (within 6 months) transaminase and bilirubin levels before initiation of therapy.***
- ***Will not be approved for use in combination therapy***
- ***Requires step therapy. See Gilenya criteria for more information.***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name		Recipient Date of Birth	Recipient Medicaid ID Number
Prescriber Name		Specialist involved in therapy:	
Prescriber NPI		Telephone Number	Fax Number
Address		City	State / Zip Code
Requested Drug and Dosage: □ **Gilenya**	**Diagnosis for this request:**	**Has the patient been vaccinated against or have a history of varicella zoster virus?** □ YES □ NO	**Appt. date for first dose:**
Qualifications for coverage:			
Current electrocardiogram **Date:**	**Current CBC** **Date:**	**Ophthalmologic Evaluation** **Date:**	**Transaminase/Bilirubin levels** **Date:**
Failed therapy (list all):		Start Date: Dose:	End Date: Frequency:
Prescriber (or Staff) / Pharmacy Signature			Date

Part II: TO BE COMPLETED BY PHARMACY

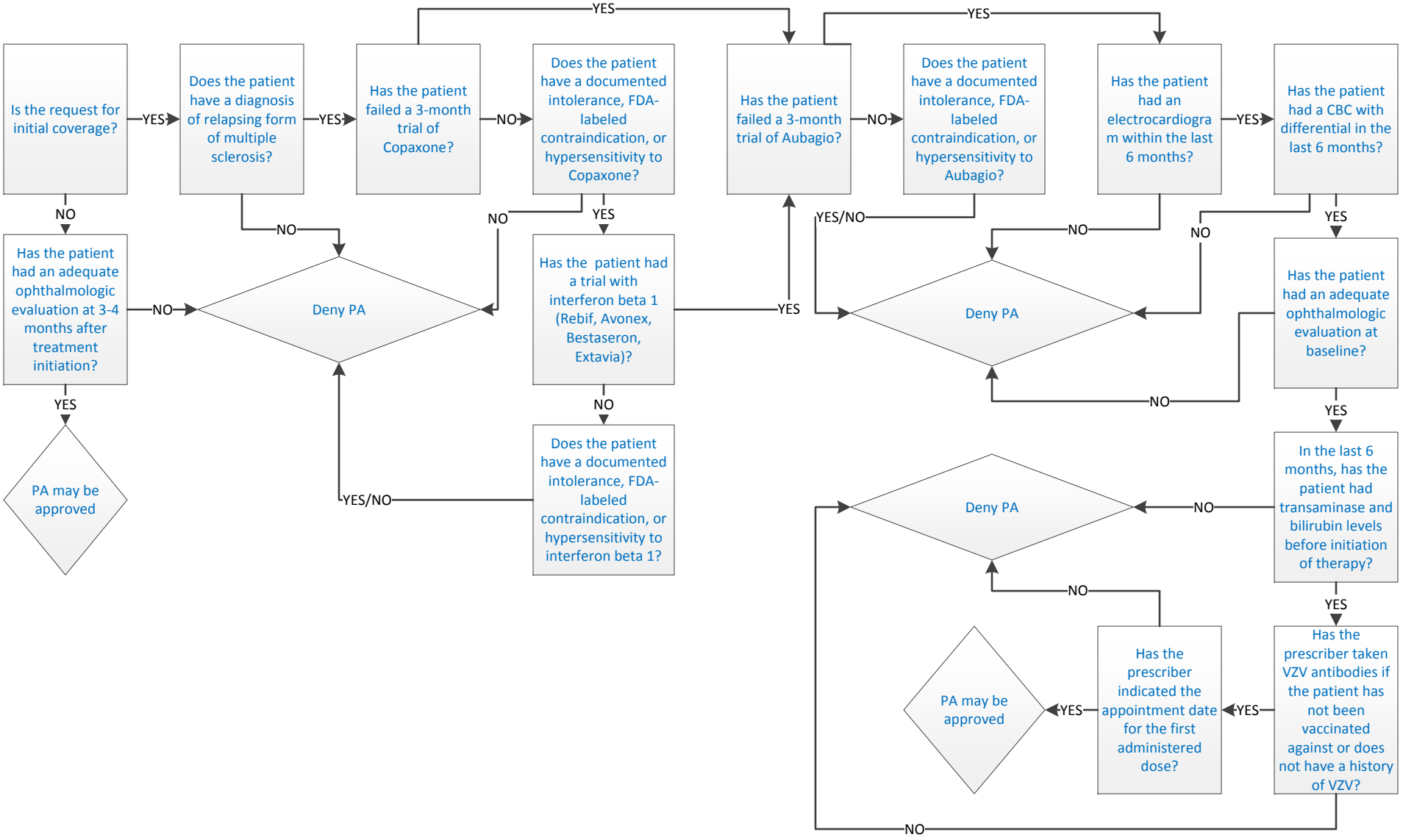
PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

Revised: 06/04/2015

North Dakota Department of Human Services
Gilenya Authorization Algorithm



GLP-1 RECEPTOR AGONISTS
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 GLP-1 receptor agonists must meet the following criteria:

- **Patient must have a diagnosis of type 2 diabetes mellitus.**
- **Patient must fail a trial of metformin, sulfonylurea, combination of metformin/sulfonylurea, or a combination of metformin and a thiazolidinedione AND a trial of Byetta.**

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ BYETTA □ TRULICITY □ BYDUREON □ VICTOZA □ TANZEUM	Diagnosis: Current Hgb A1c: Test Date:	Trial: Start Date: End Date:	Trial: Start Date: End Date:
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature		Date	

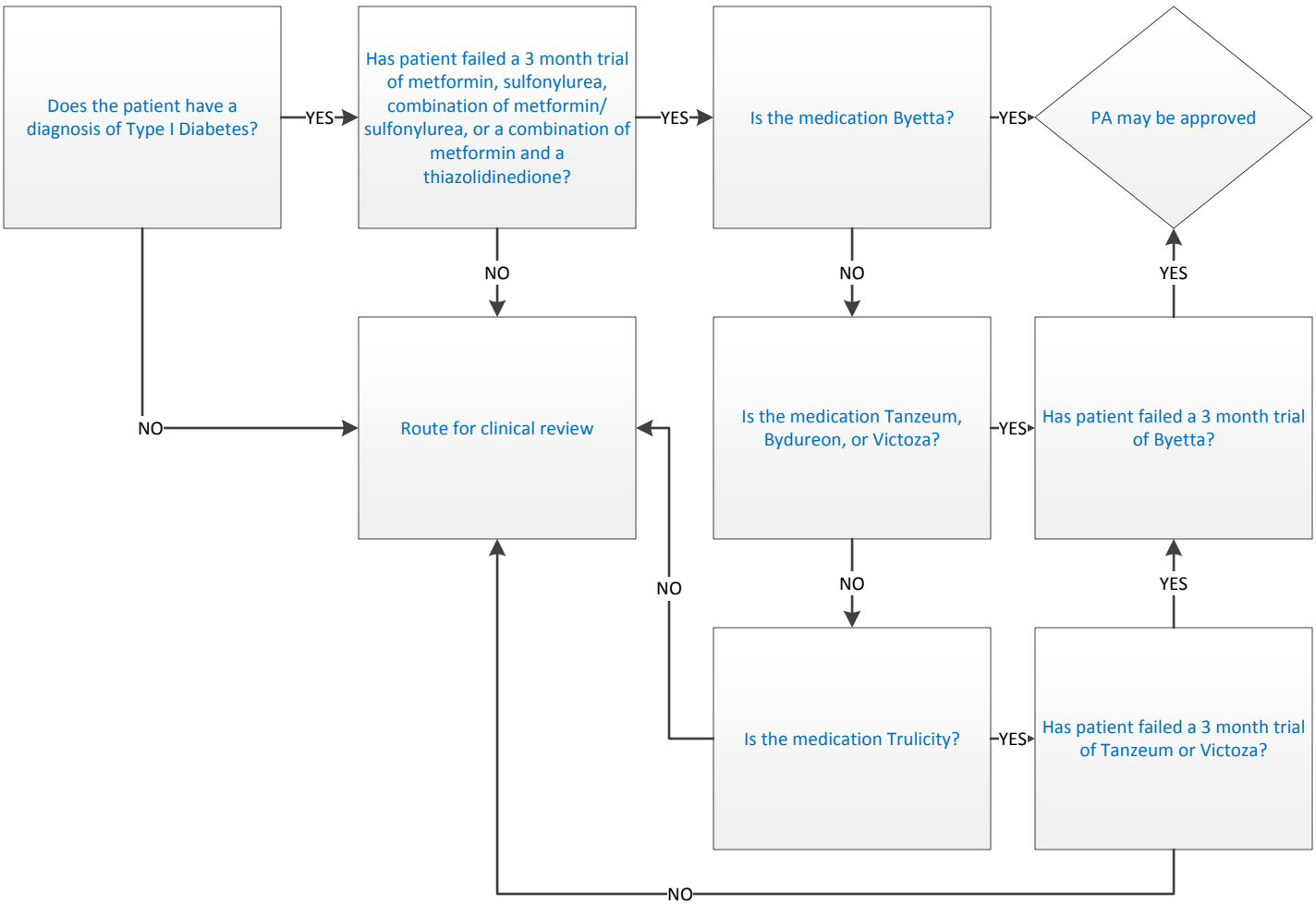
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
GLP-1 Agonists Authorization Algorithm



GRALISE PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Gralise must meet the following criteria:

- **Patient must have a diagnosis of postherpetic neuralgia**
- **Patient must first try gabapentin**

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ GRALISE	**Diagnosis for this Request:**		
Failed Therapy (dose and frequency): □ GABAPENTIN	**Start Date:** **End Date:**		
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature		Date	

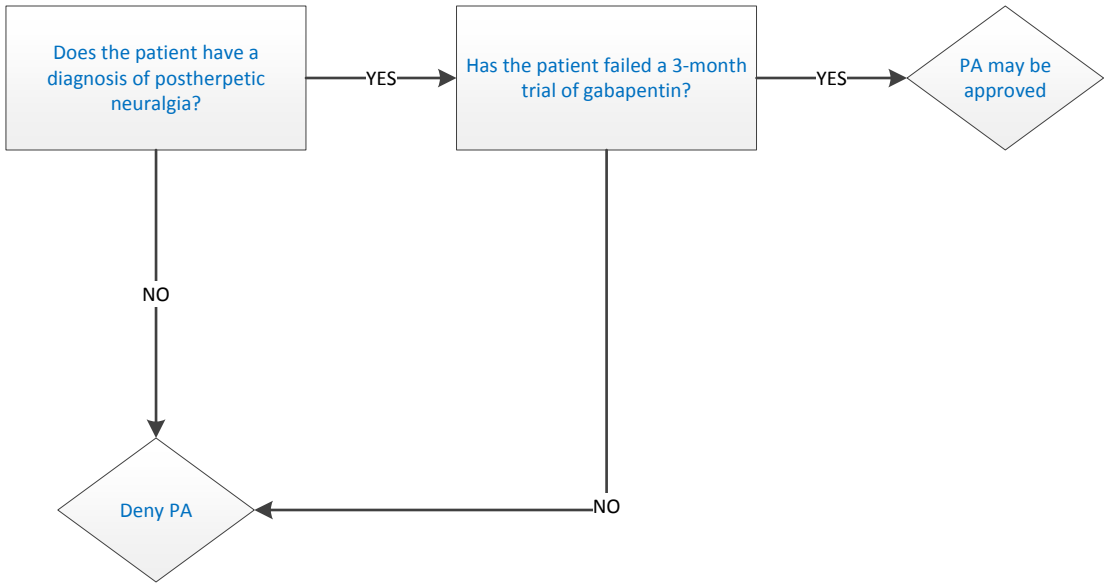
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Gralise Authorization Algorithm



Growth Hormone PA Form

health information designs

Prior Authorization Vendor for ND Medicaid

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

ND Medicaid requires that patients receiving Growth Hormone meet one of the criteria below:

- **Growth Hormone Deficiency in children and adults with a history of hypothalamic pituitary disease**
- **Short stature associated with chronic renal insufficiency before renal transplantation**
- **Short stature in patients with Turners Syndrome (TS) or Prader-Willi Syndrome (PWS)**
- **Human Immunodeficiency Virus (HIV) associated wasting in adults**

Part I: TO BE COMPLETED BY PRESCRIBER

RECIPIENT NAME:		RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /		
PRESCRIBER NAME		PRESCRIBER NPI:
Address:		Phone: ( )
City:		FAX: ( )
State: Zip:		

REQUESTED DRUG:	**Requested Dosage:** (must be completed)

Qualifications for coverage:

Criteria met:	Diagnosis Date:	Dose:
	Drug:	Frequency:

PRESCRIBER (or Staff) / PHARMACY SIGNATURE DATE:

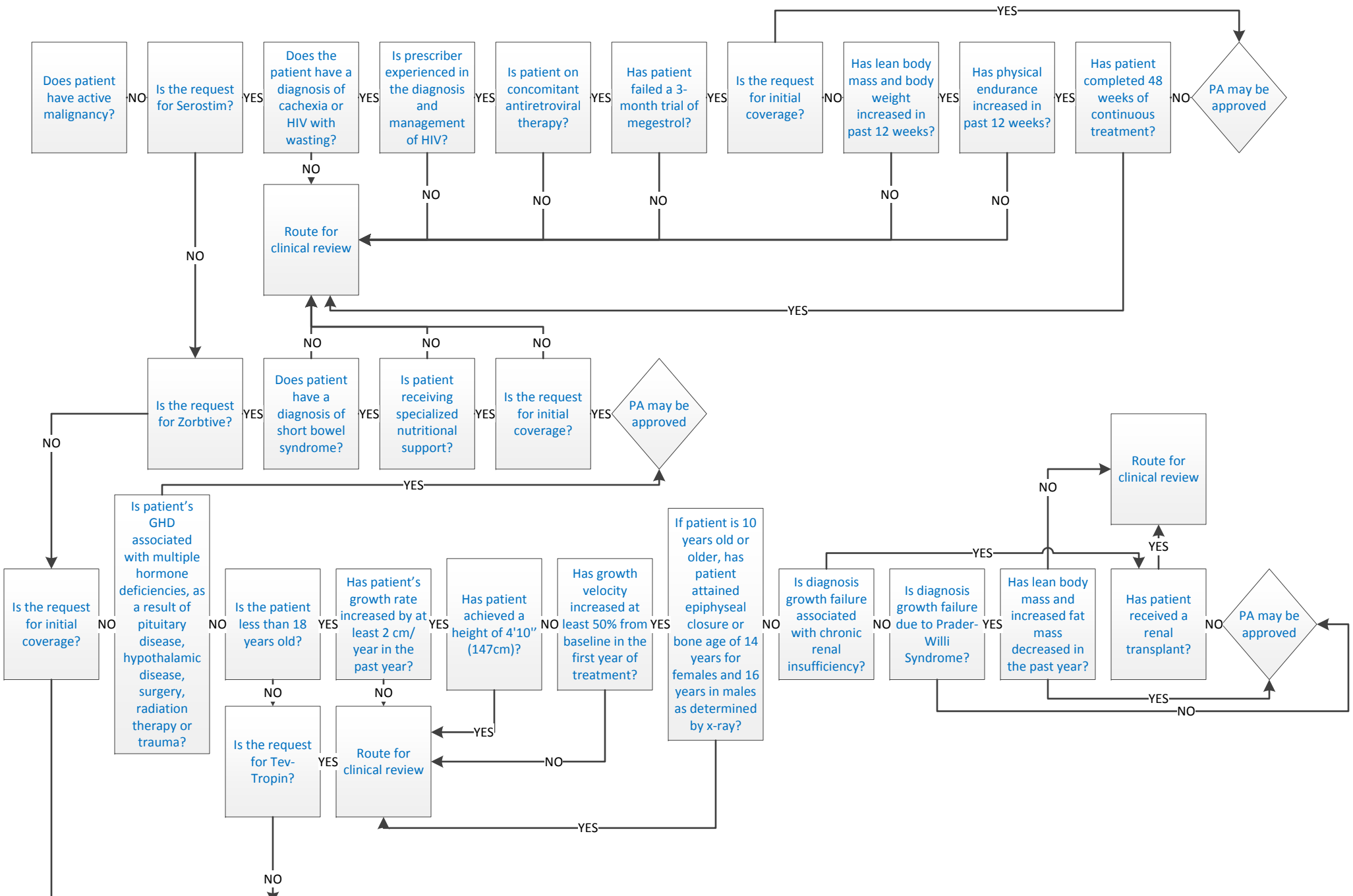
Part II: TO BE COMPLETED BY PHARMACY

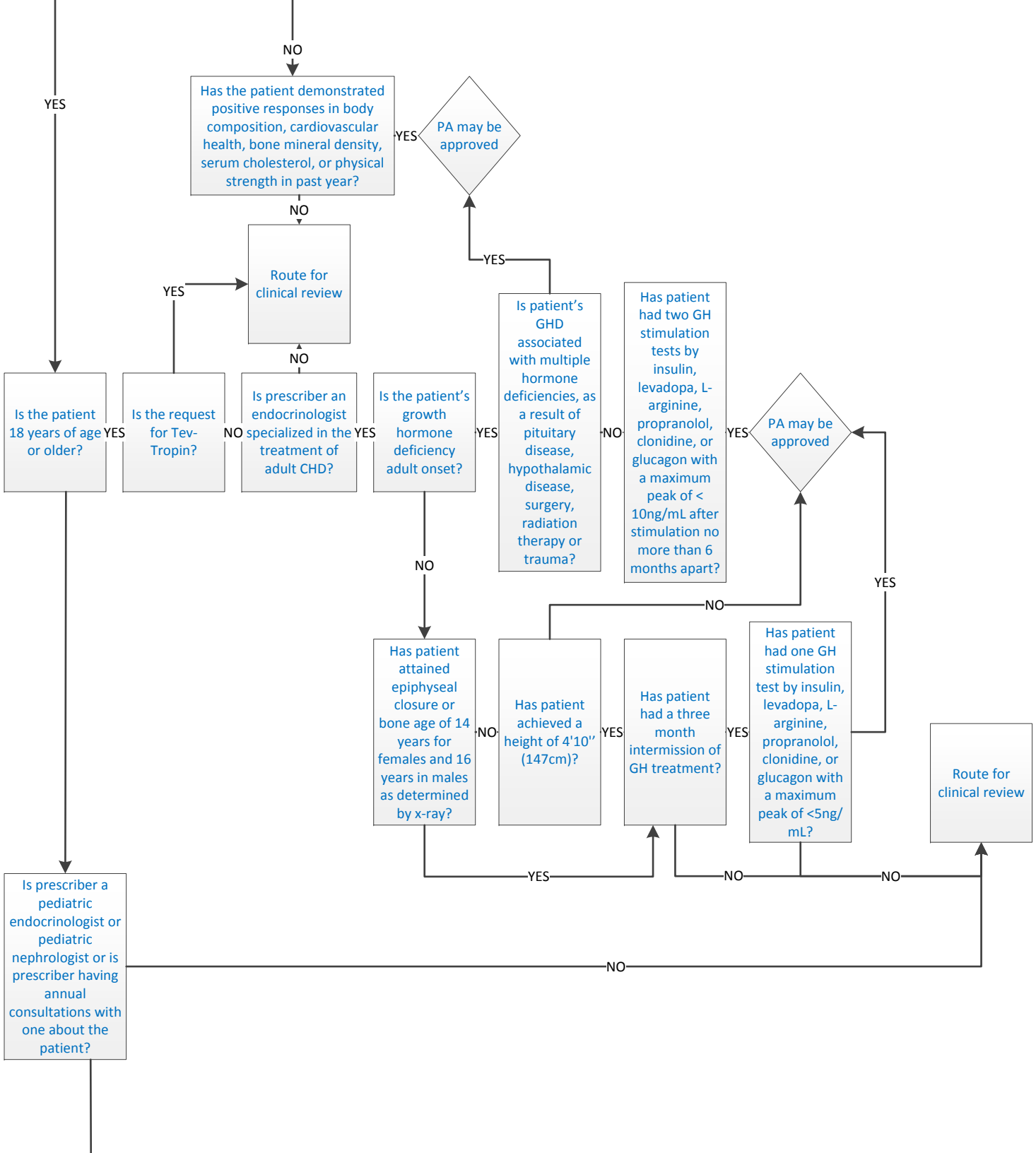
PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

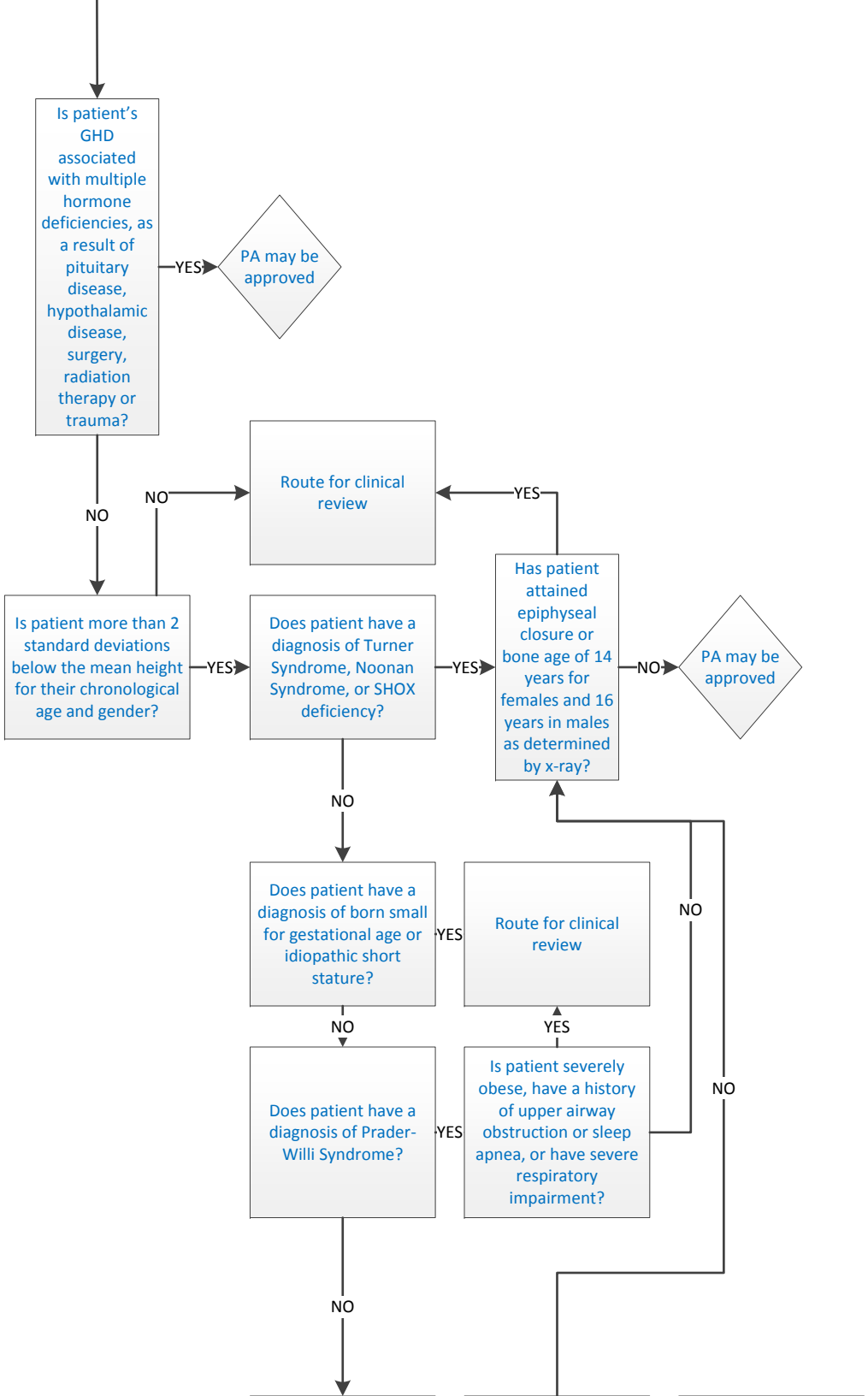
Part III: FOR OFFICIAL USE ONLY

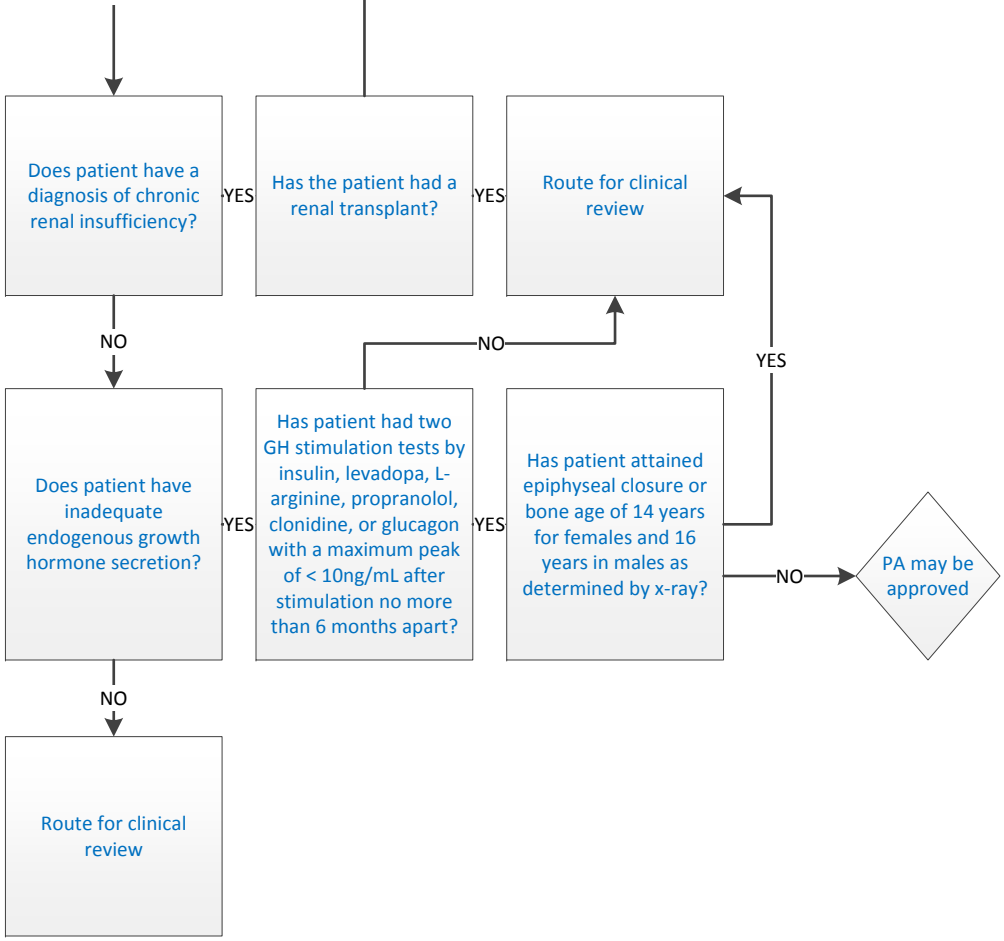
Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	

North Dakota Department of Human Services
Growth Hormone Authorization Algorithm




NO
Has the patient demonstrated positive responses in body composition, cardiovascular health, bone mineral density, serum cholesterol, or physical strength in past year?
YES
PA may be approved
YES
NO
Route for clinical review
YES
NO
Is the patient 18 years of age or older?
YES
Is the request for Tev-Tropin?
NO
Is prescriber an endocrinologist specialized in the treatment of adult CHD?
YES
Is the patient's growth hormone deficiency adult onset?
YES
Is patient's GHD associated with multiple hormone deficiencies, as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma?
NO
Has patient had two GH stimulation tests by insulin, levadopa, L-arginine, propranolol, clonidine, or glucagon with a maximum peak of < 10ng/mL after stimulation no more than 6 months apart?
YES
PA may be approved
YES
NO
NO
Has patient attained epiphyseal closure or bone age of 14 years for females and 16 years in males as determined by x-ray?
NO
Has patient achieved a height of 4'10'' (147cm)?
YES
Has patient had a three month intermission of GH treatment?
YES
Has patient had one GH stimulation test by insulin, levadopa, L-arginine, propranolol, clonidine, or glucagon with a maximum peak of <5ng/mL?
YES
Route for clinical review
YES
NO
NO
Is prescriber a pediatric endocrinologist or pediatric nephrologist or is prescriber having annual consultations with one about the patient?
NO


Is patient's GHD associated with multiple hormone deficiencies, as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma?
YES
PA may be approved
NO
NO
Route for clinical review
YES
Is patient more than 2 standard deviations below the mean height for their chronological age and gender?
YES
Does patient have a diagnosis of Turner Syndrome, Noonan Syndrome, or SHOX deficiency?
YES
Has patient attained epiphyseal closure or bone age of 14 years for females and 16 years in males as determined by x-ray?
NO
PA may be approved
NO
Does patient have a diagnosis of born small for gestational age or idiopathic short stature?
YES
Route for clinical review
NO
NO
NO
NO
YES
Does patient have a diagnosis of Prader-Willi Syndrome?
YES
Is patient severely obese, have a history of upper airway obstruction or sleep apnea, or have severe respiratory impairment?
NO
NO


Does patient have a diagnosis of chronic renal insufficiency?
YES
Has the patient had a renal transplant?
YES
Route for clinical review
NO
NO
YES
Does patient have inadequate endogenous growth hormone secretion?
YES
Has patient had two GH stimulation tests by insulin, levadopa, L-arginine, propranolol, clonidine, or glucagon with a maximum peak of < 10ng/mL after stimulation no more than 6 months apart?
YES
Has patient attained epiphyseal closure or bone age of 14 years for females and 16 years in males as determined by x-ray?
NO
PA may be approved
NO
Route for clinical review

health information designs

Genitourinary Smooth Muscle Relaxants (GSMR) Prior Authorization

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 patients who are prescribed GSMRs must follow these guidelines:

Note:

- **Patient must have an FDA approved indication for the medication requested.**
- **Patient must try oxybutynin or oxybutynin ER.**
- **Requires step therapy. See GSMR criteria for more information.**
-

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI:	Telephone Number	Fax Number	
Address	City	State	Zip Code
Qualifications for coverage:			
Requested Drug and Dosage: □ **Enablex** □ **Detrol LA** □ **Toviaz** □ **Gelnique** □ **Myrbetriq** □ **Gelnique Sachets** □ **Oxytrol** □ **Detrol** □ **Sanctura** □ **Vesicare** □ **Sanctura XR**	**Diagnosis for this request:** **Failed therapy-List all (Drug and Dose)** **Start Date:** **End Date:**		
Prescriber (or Staff) / Pharmacy Signature		Date	

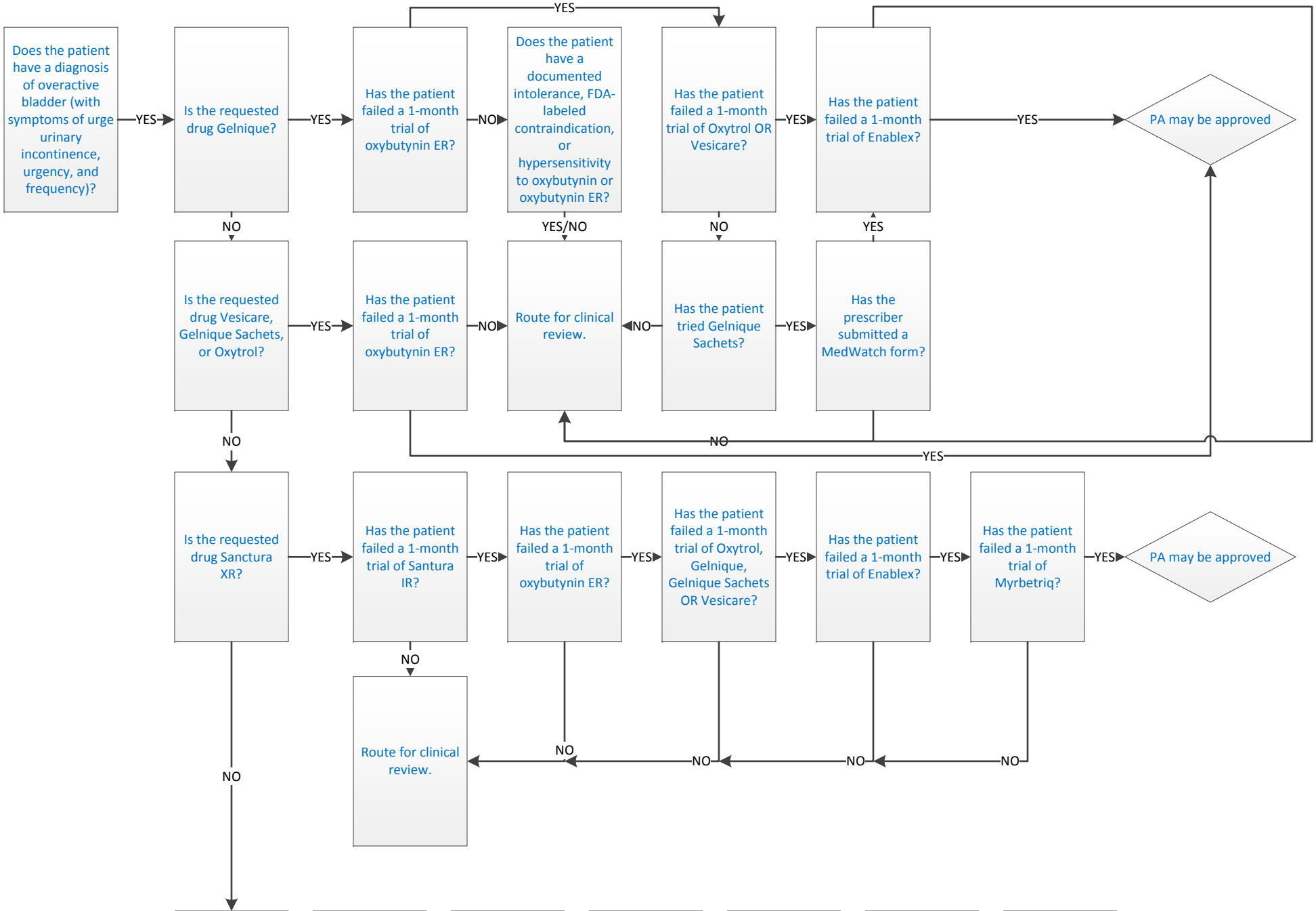
Part II: TO BE COMPLETED BY PHARMACY

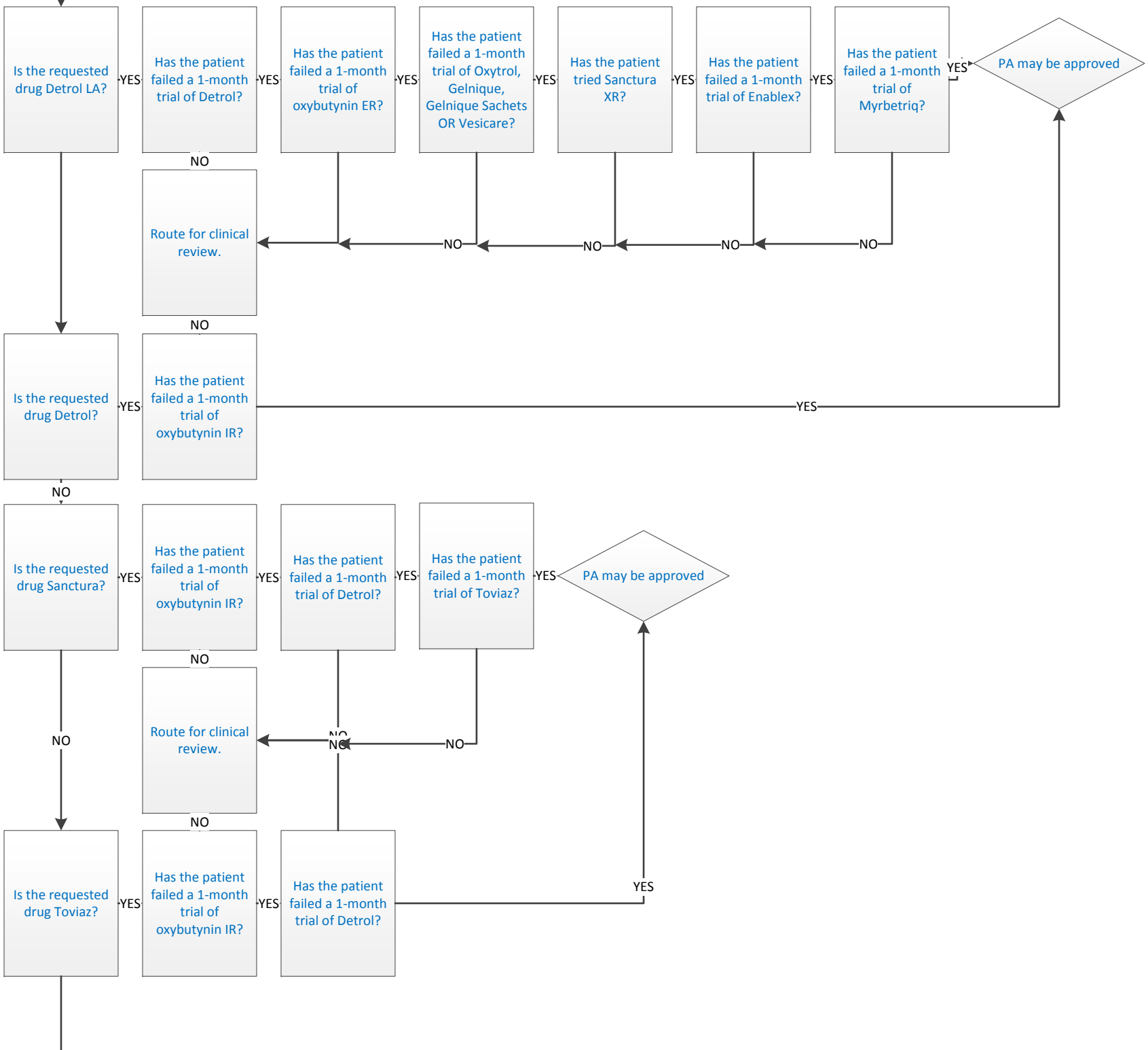
PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE NUMBER	FAX NUMBER	DRUG	NDC #

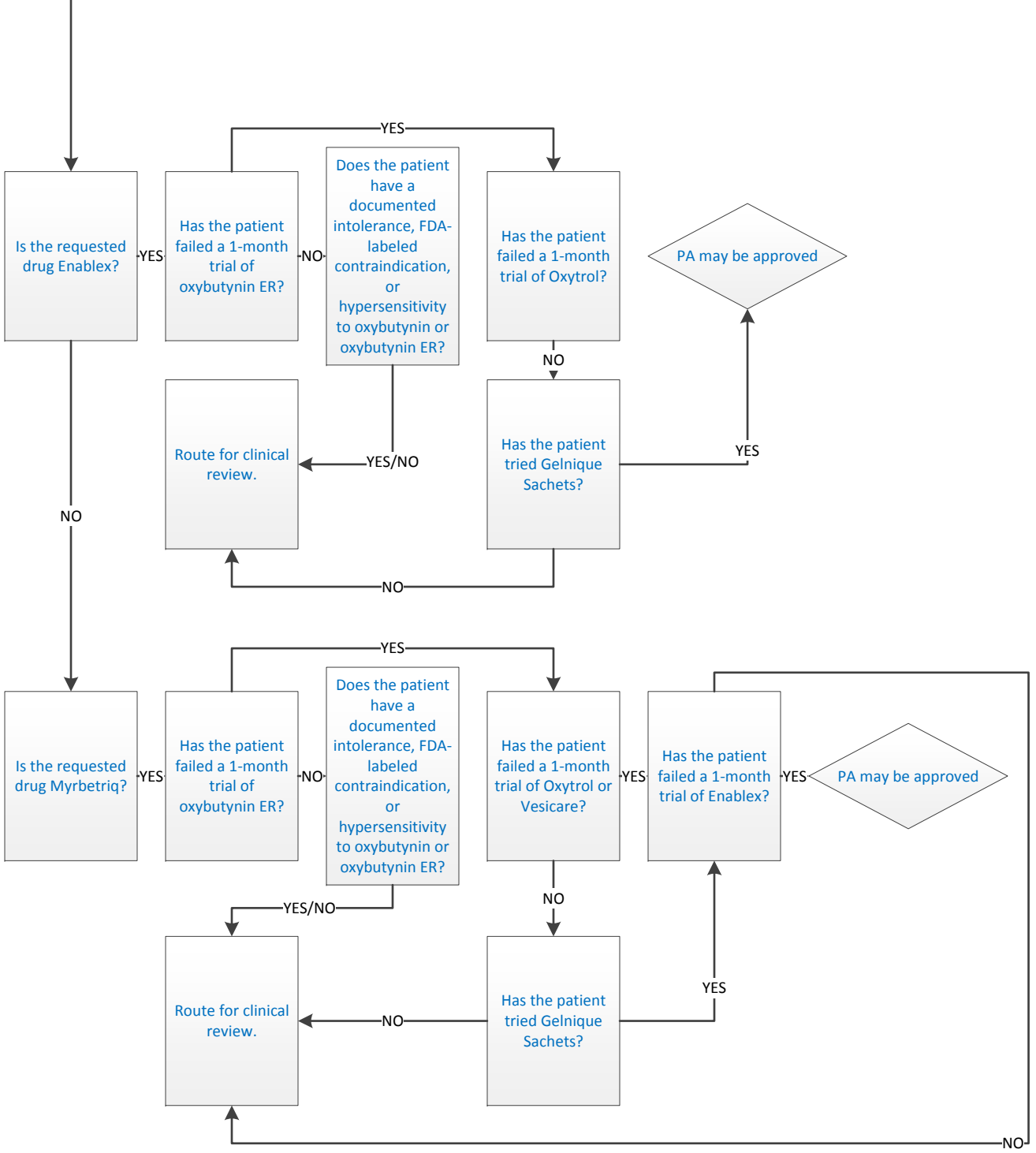
Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Genitourinary Smooth Muscle Relaxant Authorization Algorithm




Is the requested drug Detrol LA?
YES
Has the patient failed a 1-month trial of Detrol?
YES
Has the patient failed a 1-month trial of oxybutynin ER?
YES
Has the patient failed a 1-month trial of Oxytrol, Gelnique, Gelnique Sachets OR Vesicare?
YES
Has the patient tried Sanctura XR?
YES
Has the patient failed a 1-month trial of Enablex?
YES
Has the patient failed a 1-month trial of Myrbetriq?
YES
PA may be approved
NO
Route for clinical review.
NO
NO
NO
NO
NO
Is the requested drug Detrol?
YES
Has the patient failed a 1-month trial of oxybutynin IR?
YES
NO
Is the requested drug Sanctura?
YES
Has the patient failed a 1-month trial of oxybutynin IR?
YES
Has the patient failed a 1-month trial of Detrol?
YES
Has the patient failed a 1-month trial of Toviaz?
YES
PA may be approved
NO
Route for clinical review.
NO
NO
NO
NO
Is the requested drug Toviaz?
YES
Has the patient failed a 1-month trial of oxybutynin IR?
YES
Has the patient failed a 1-month trial of Detrol?
YES


Is the requested drug Enablex?
YES
Has the patient failed a 1-month trial of oxybutynin ER?
NO
Does the patient have a documented intolerance, FDA-labeled contraindication, or hypersensitivity to oxybutynin or oxybutynin ER?
YES
Has the patient failed a 1-month trial of Oxytrol?
NO
PA may be approved
Route for clinical review.
YES/NO
Has the patient tried Gelnique Sachets?
YES
NO
NO
Is the requested drug Myrbetriq?
YES
Has the patient failed a 1-month trial of oxybutynin ER?
NO
Does the patient have a documented intolerance, FDA-labeled contraindication, or hypersensitivity to oxybutynin or oxybutynin ER?
YES
Has the patient failed a 1-month trial of Oxytrol or Vesicare?
YES
Has the patient failed a 1-month trial of Enablex?
YES
PA may be approved
YES/NO
NO
Route for clinical review.
NO
Has the patient tried Gelnique Sachets?
YES
NO

HEREDITARY ANGIOEDEMA
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 an agent used to treat hereditary angioedema must meet the following criteria:

- **Patient must have diagnosis of hereditary angioedema confirmed by a specialist**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name	Specialist Involved in therapy:		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ BERINERT □ FIRAZYR □ CINRYZE □ KALBITOR	**Diagnosis for this Request:**		
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature	Date		

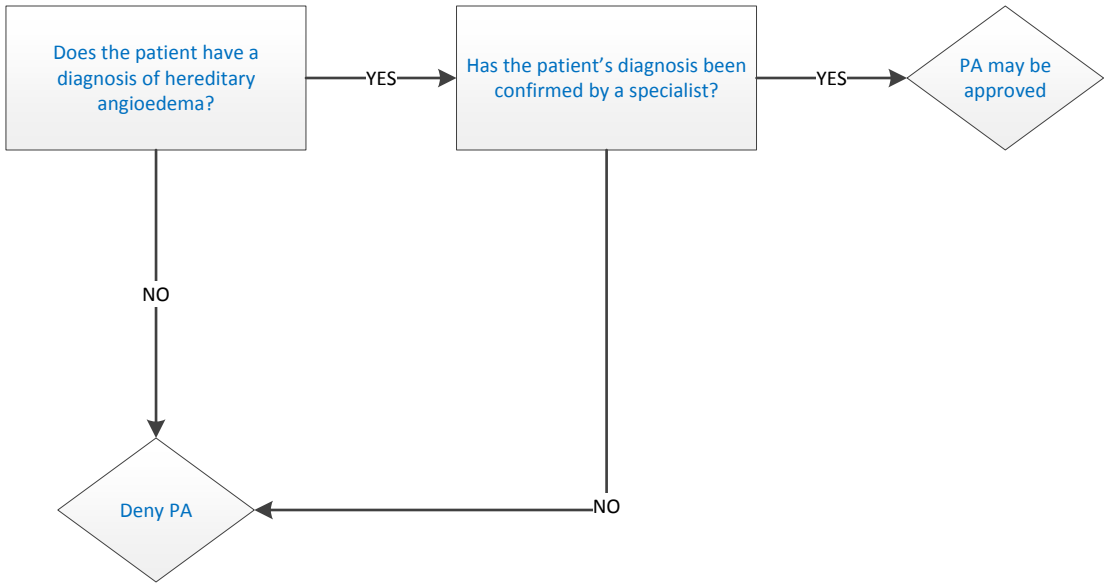
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Hereditary Angioedema Agents Authorization Algorithm



HARVONI PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Harvoni must meet the following criteria:

- Patient must be ≥ 18 years old.
- Must have a diagnosis of chronic hepatitis C (genotypes 1).
- Liver biopsy showing fibrosis corresponding to a Metavir score of greater than or equal to 2 or Ishak score of greater than or equal to 3 or other accepted test demonstrating liver fibrosis.
- Must be prescribed by or in consultation with a hepatologist, gastroenterologist, or infectious disease specialist.
- Absence of renal impairment (eGFR must be >30mL/min/1.73m^2) and absence of end stage renal disease (ESRD).
- Documentation showing that patient is drug and alcohol free for the past 12 months
- The concomitant use of Harvoni and P-gp inducers (rifampin, St. John's wort), certain anticonvulsants, certain antiretrovirals, and rosuvastatin is not recommended.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug □ **Harvoni** Dosage: _____	**Documented liver fibrosis:** **Is patient awaiting liver transplant?**	**Diagnosis for this request:** **Genotype:**	**Patient is drug and alcohol free for past 12 months:** □ YES □ NO *PROVIDE DOCUMENTATION **eGFR:**

Has the patient been previously treated for chronic hepatitis C? □ YES □ NO If yes, please indicate past treatment regimen(s), dates of treatment, and response to therapy: Has patient attested that they will continue treatment without interruption for the duration of therapy? □ YES □ NO Is the patient taking P-gp inducers, anticonvulsants, antiretrovirals, rosuvastatin, or amiodorone? □ YES □ NO	Baseline HCV RNA: HCV RNA 4 weeks after starting therapy: Metavir Score: Ishak Score:
Prescriber (or Staff) / Pharmacy Signature	Date

Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

Hepatitis C Patient Consent Form

I, _____, have been counseled by my healthcare provider on the following:

- ☐ I agree to complete the entire course of treatment and have laboratory tests before starting, during, and after completing treatment as ordered by my healthcare provider.
- ☐ I understand that for the medication to work, it is important that I take my medication each day for the entire course of treatment.
- ☐ I understand the importance to not drink alcohol or use illicit drugs during and after my treatment for Hepatitis C.
- ☐ I understand how to avoid being re-infected with Hepatitis C during and after my treatment.
- ☐ (Females) I understand that these drugs are harmful to babies. I will use two methods to avoid getting pregnant. I understand that this medication may cause serious birth defects to an unborn child for up to 6 months after I have completed my treatment.
- ☐ (Males) I understand that while I am taking the medication, I must avoid getting my partner pregnant. If my partner becomes pregnant, the baby may have serious birth defects. My partner and I will prevent pregnancy using two forms of birth control for up to 6 months after my treatment is complete. If I have a committed partner, I have discussed these risks with her.

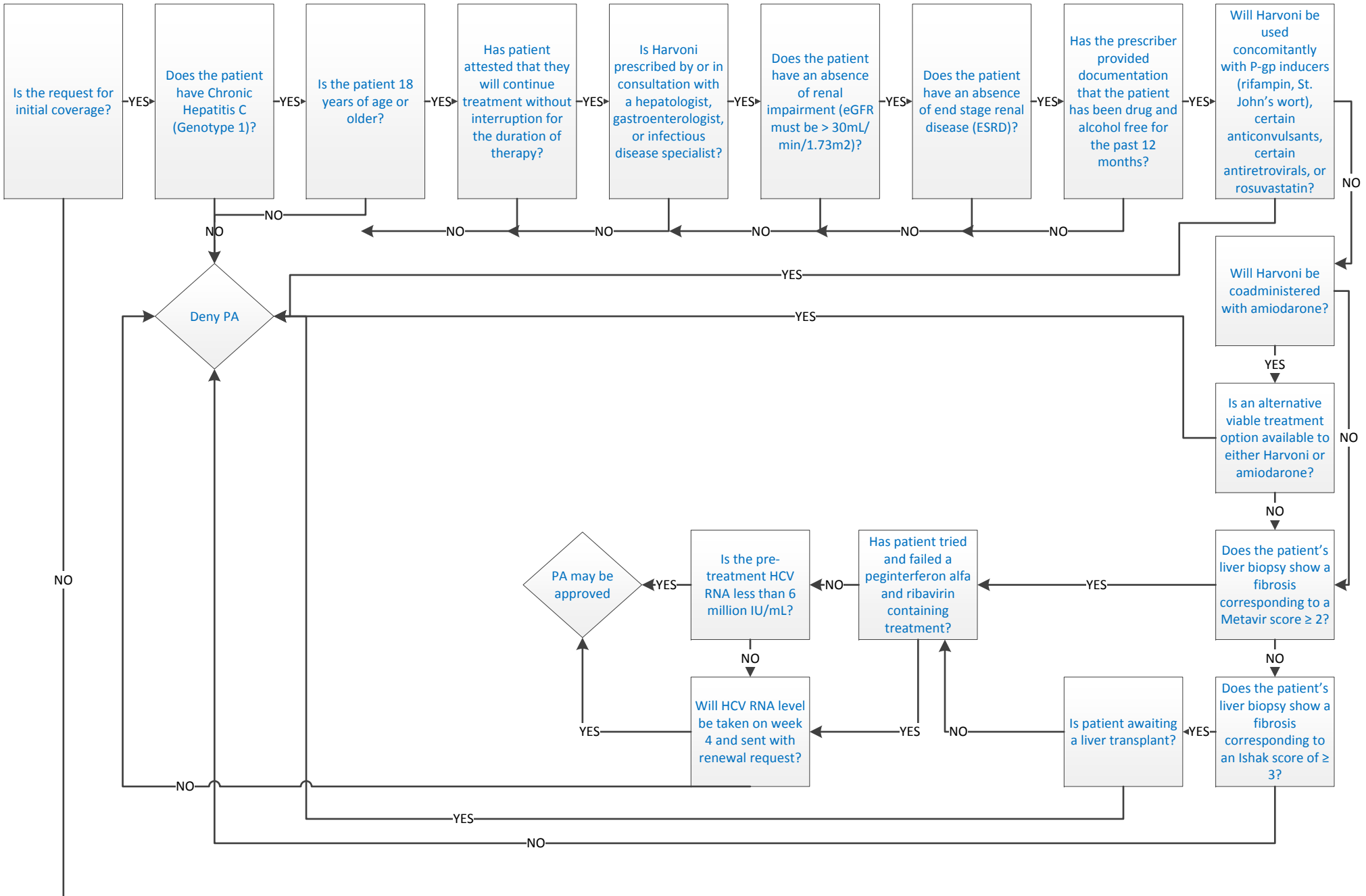
Patient Signature _____ Date __/__/____

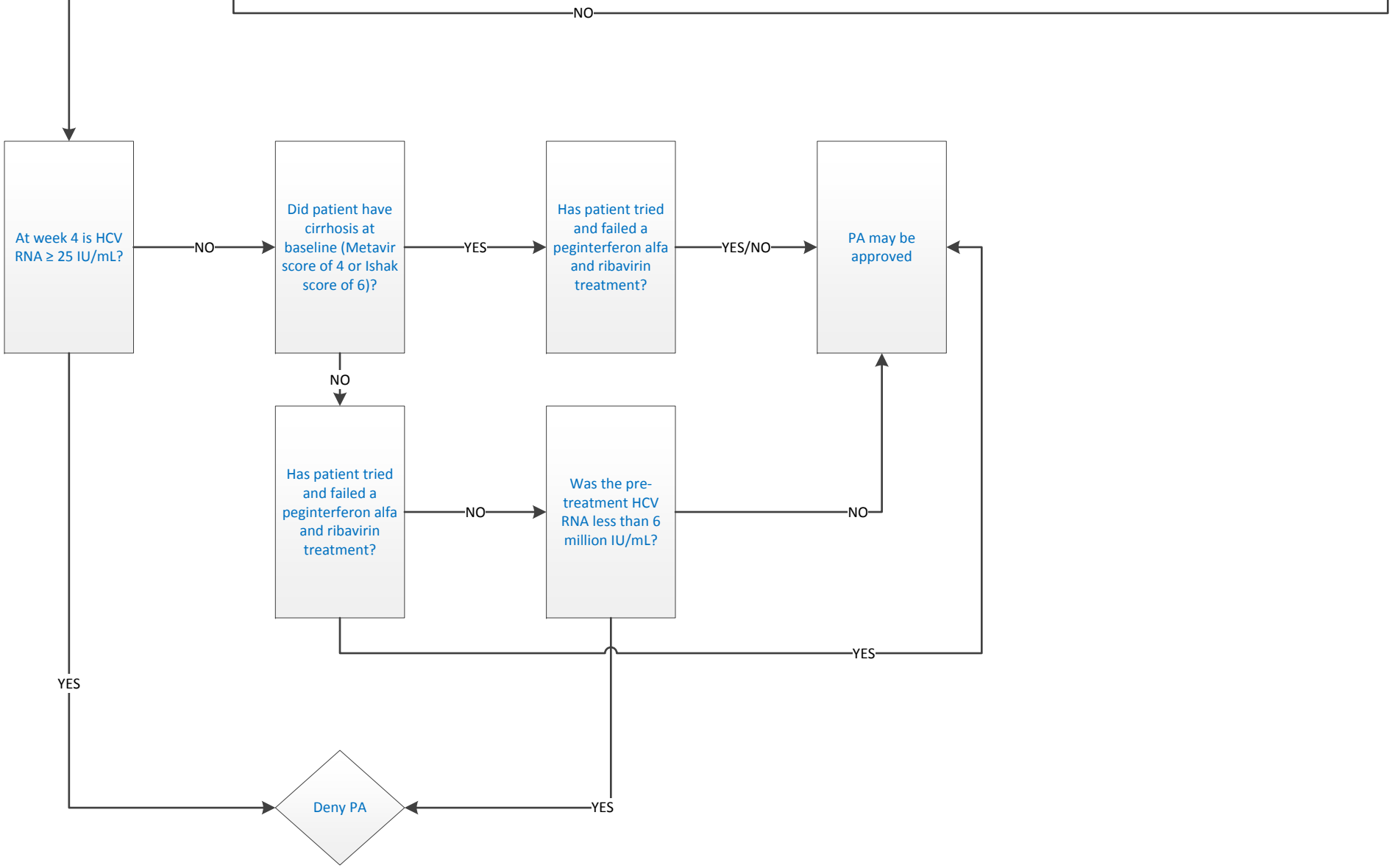
Pharmacy or Prescriber Representative:

Signature _____ Date __/__/____

By signature, the pharmacy or prescriber representative confirms the contract has been reviewed with the patient.

North Dakota Department of Human Services
Harvoni Authorization Algorithm




NO
At week 4 is HCV RNA ≥ 25 IU/mL?
NO
Did patient have cirrhosis at baseline (Metavir score of 4 or Ishak score of 6)?
YES
Has patient tried and failed a peginterferon alfa and ribavirin treatment?
YES/NO
PA may be approved
NO
Has patient tried and failed a peginterferon alfa and ribavirin treatment?
NO
Was the pre-treatment HCV RNA less than 6 million IU/mL?
NO
YES
YES
Deny PA
YES

HEMANGEOL
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Hemangeol must meet the following criteria:

- **Patient must be between 5 weeks and 1 year of age.**
- **Patient must weigh 2 kg or greater.**
- **Patient must not have contraindications as listed below: asthma or a history of bronchospasm, bradycardia (<80 beats per minute), greater than first-degree heart block, decompensated heart failure, blood pressure <50/30 mmHg, or pheochromocytoma.**
- **Patient must have a diagnosis of proliferating infantile hemangioma requiring systemic therapy.**

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ HEMANGEOL	Diagnosis: Patient's weight:	Does patient have ANY contraindications to Hemangeol?	
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature		Date	

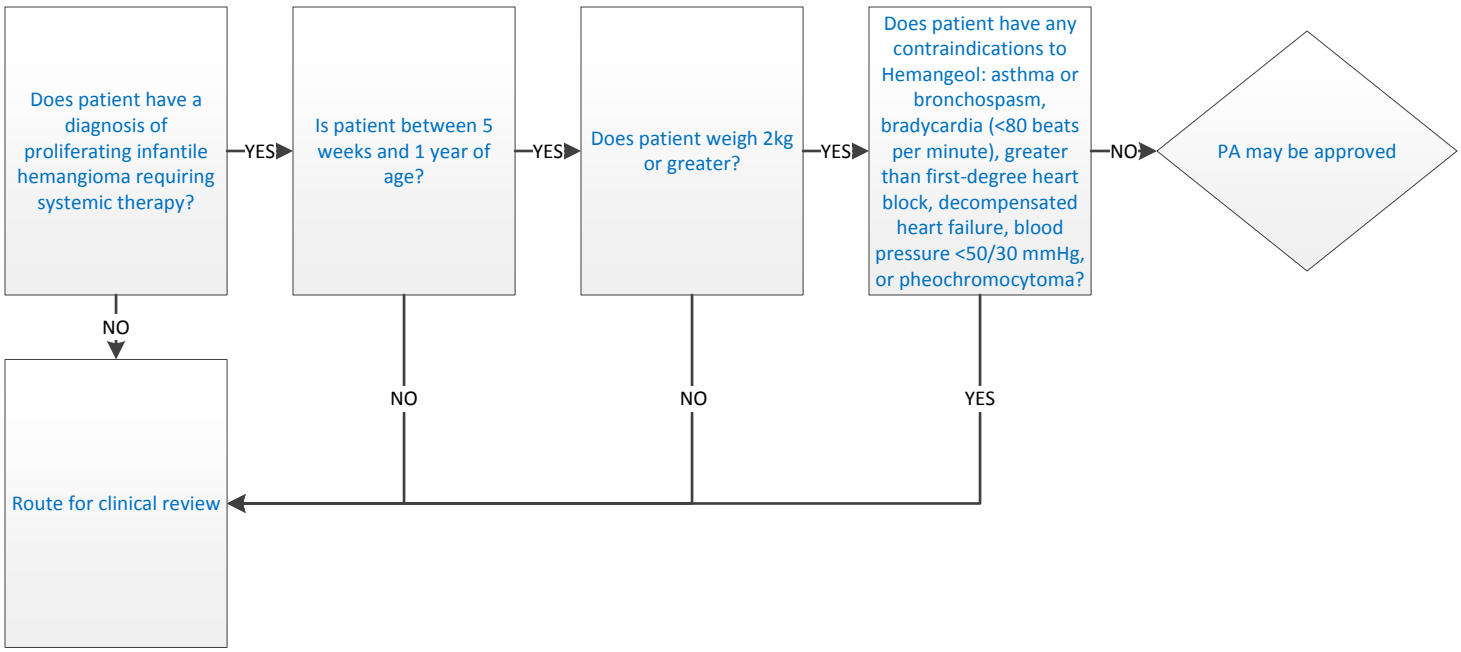
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Hemangeol Authorization Algorithm



health information designs

Hepatitis C Virus (HCV) Medication Prior Authorization

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 patients receiving a prescription for Intron, Infergen, Pegasys or PegIntron must submit a prior authorization form.

Note:

- ***Prior authorization will be granted if the requested product has been approved by the FDA for the indication listed below.***
- ***Current recommended therapy of chronic HCV infection is the combination of pegylated interferon alfa (PEGIntron or Pegasys) and ribavirin.***
- ***Victrelis patients must be 18 years of age or older.***
- ***Victrelis will only be approved for 12 weeks for review of HCV-RNA levels and compliance.***

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ **Victrelis**	**Diagnosis for this request:**	**Genotype:**	
	Ribavirin dose: **Peg-interferon dose:**		
Prescriber (or Staff) / Pharmacy Signature		Date	

Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: /	Approved by:
Denied: (Reasons)	

Hepatitis C Patient Consent Form

I, _____, have been counseled by my healthcare provider on the following:

- ☐ I agree to complete the entire course of treatment and have laboratory tests before starting, during, and after completing treatment as ordered by my healthcare provider.
- ☐ I understand that for the medication to work, it is important that I take my medication each day for the entire course of treatment.
- ☐ I understand the importance to not drink alcohol or use illicit drugs during and after my treatment for Hepatitis C.
- ☐ I understand how to avoid being re-infected with Hepatitis C during and after my treatment.
- ☐ (Females) I understand that these drugs are harmful to babies. I will use two methods to avoid getting pregnant. I understand that this medication may cause serious birth defects to an unborn child for up to 6 months after I have completed my treatment.
- ☐ (Males) I understand that while I am taking the medication, I must avoid getting my partner pregnant. If my partner becomes pregnant, the baby may have serious birth defects. My partner and I will prevent pregnancy using two forms of birth control for up to 6 months after my treatment is complete. If I have a committed partner, I have discussed these risks with her.

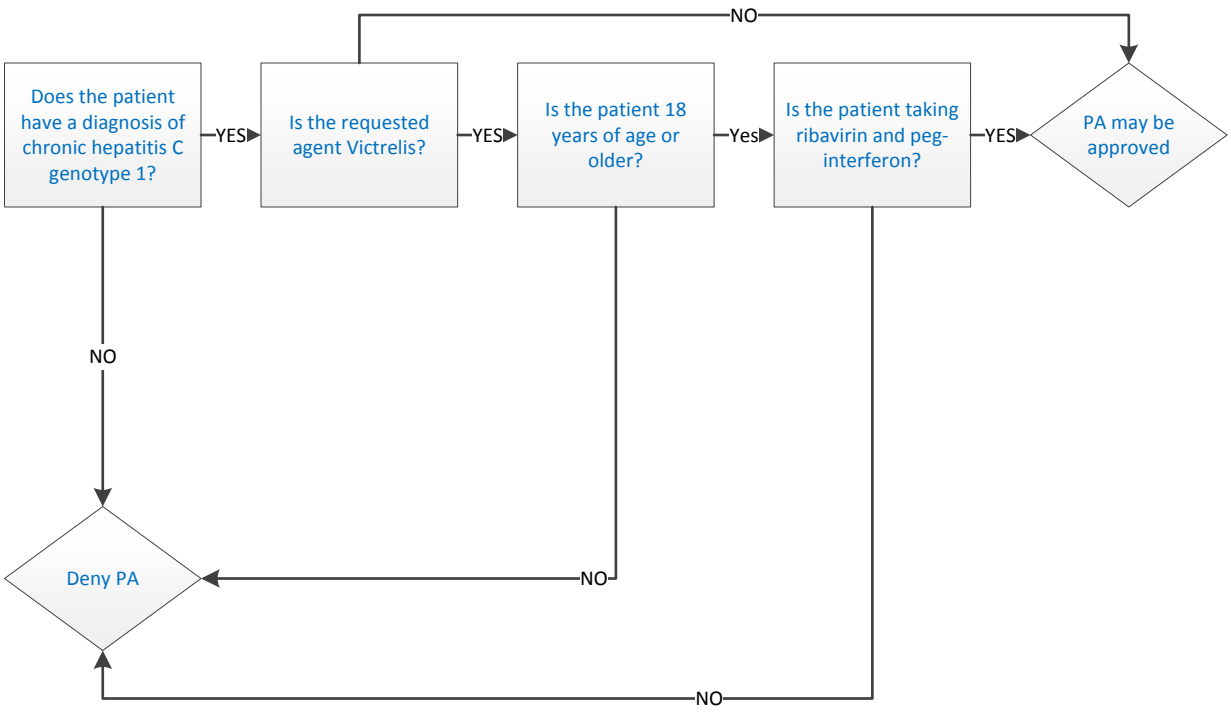
Patient Signature _____ Date __/__/____

Pharmacy or Prescriber Representative:

Signature _____ Date __/__/____

By signature, the pharmacy or prescriber representative confirms the contract has been reviewed with the patient.

North Dakota Department of Human Services
Hepatitis C Authorization Algorithm



health information designs

Prior Authorization Vendor for ND Medicaid

Horizant Prior Authorization

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 Horizant must follow the following guidelines:

- ***Patient must have a diagnosis of Restless Leg Syndrome.***
- ***Patient must have had a trial of gabapentin, pramipexole, or ropinirole.***

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ **Horizant**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED THERAPY START DATE: END DATE:	DOSE: FREQUENCY:		
Prescriber (or Staff) / Pharmacy Signature		Date	

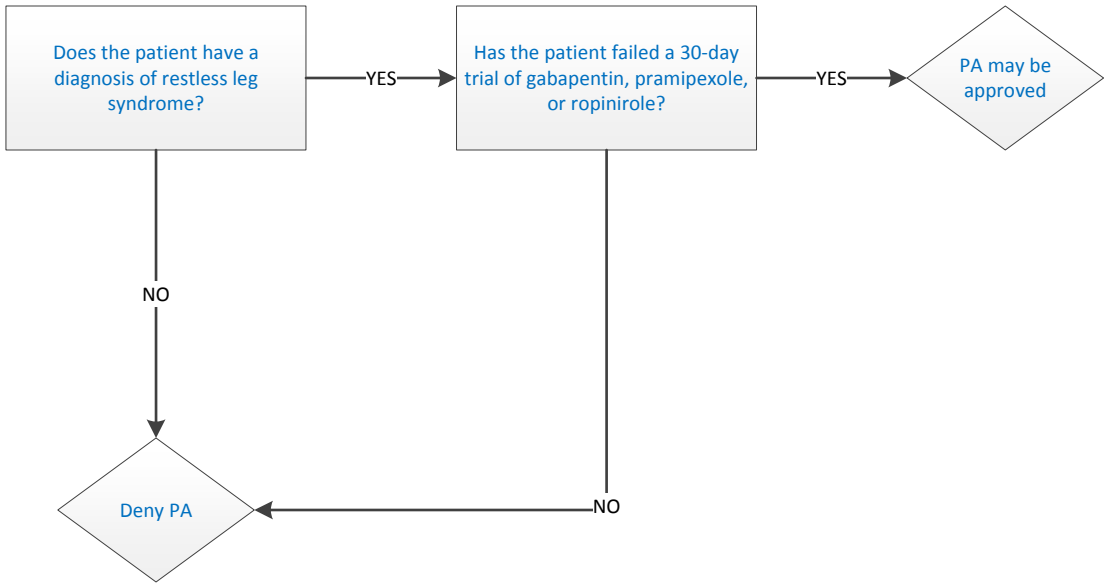
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Horizant Authorization Algorithm



INTERFERONS PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 interferon must meet the following criteria:

- **Patient must have a confirmed diagnosis of multiple sclerosis.**

Part I: TO BE COMPLETED BY PHYSICIAN

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:**		
Prescriber (or Staff) / Pharmacy Signature		Date	

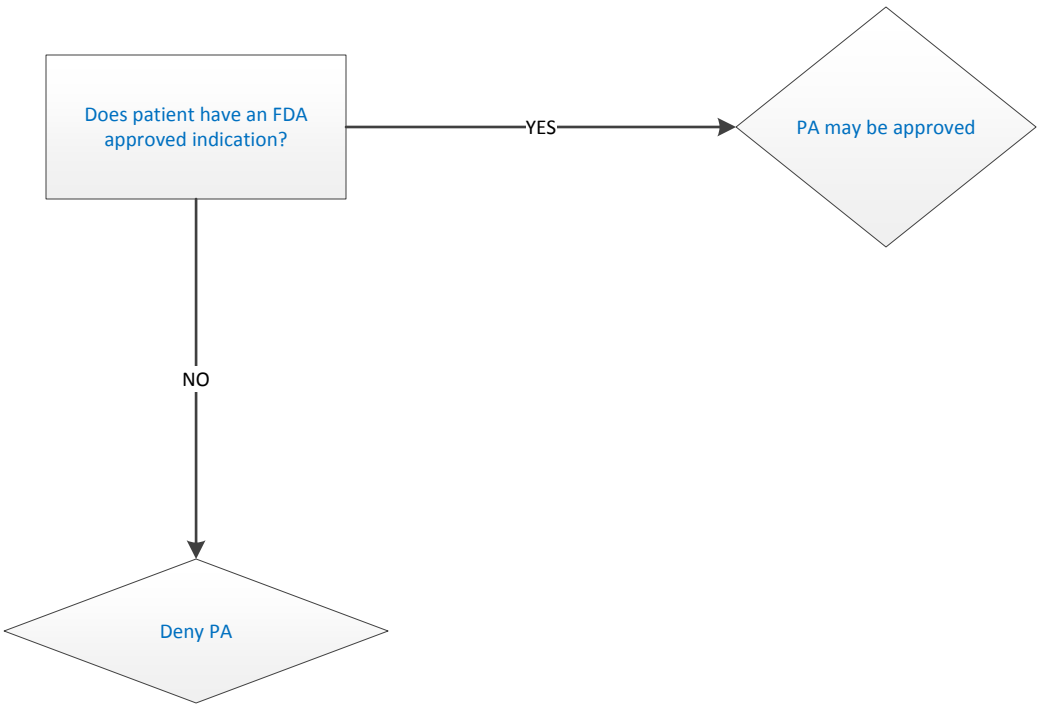
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Interferons Authorization Algorithm



health information designs

Prior Authorization Vendor for ND Medicaid

AGENTS USED TO TREAT IDIOPATHIC PULMONARY FIBROSIS PA 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 agents used to treat idiopathic pulmonary fibrosis must meet the following criteria:

- **Patient must be 18 years of age or older.**
- **Patient must have documented diagnosis of idiopathic pulmonary fibrosis.**
- **Patient must have a specialist involved in therapy.**
- **Patient must have forced vital capacity (FVC) ≥ 50% of predicted within prior 60 days.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist Involved in Therapy		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug: □ OFEV □ ESBRIET	Diagnosis: FVC:	Is patient pregnant? □ YES □ NO Is patient of child-bearing potential? □ YES □ NO Have LFTs been measured? □ YES □ NO Does patient have moderate to severe liver impairment? □ YES □ NO Does patient currently smoke? □ YES □ NO	
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature			Date

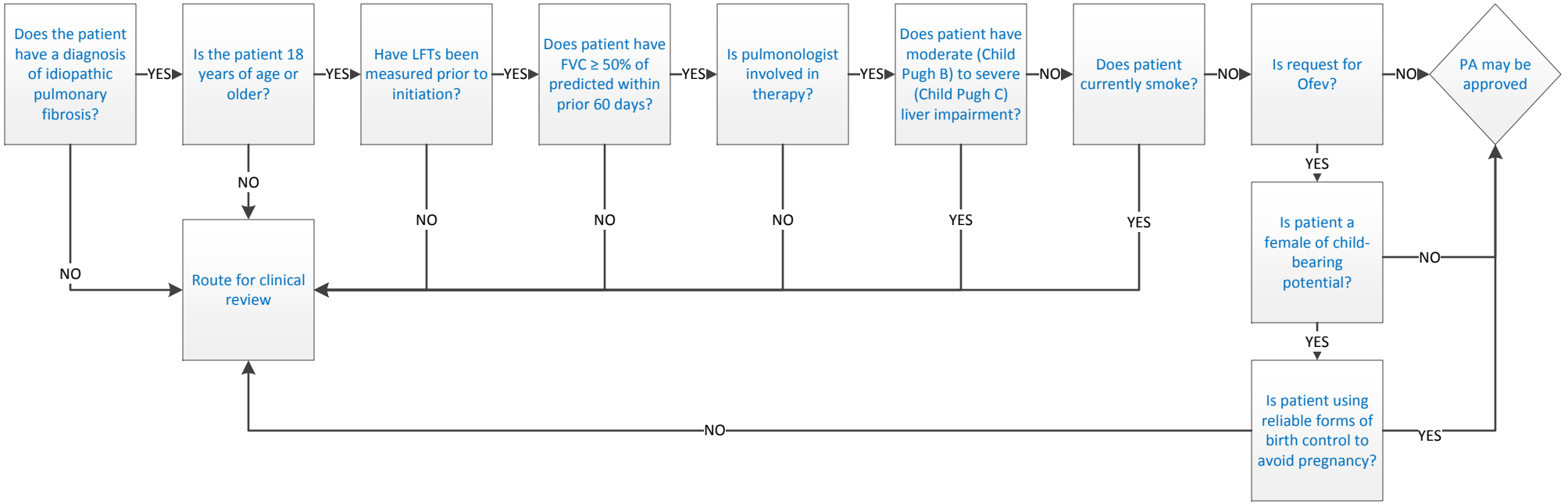
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Idiopathic Pulmonary Fibrosis Agents Authorization Algorithm



KALYDECO PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Kalydeco must meet the following criteria:

- **Patient must be 2 years of age or older and have one of the following mutations in the cystic fibrosis conductance regulator (CFTR) gene: G551D, G1244E, G1349D, G178R, G551S, R117H, S1251N, S1255P, S549N, or S549R.**

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ KALYDECO	**Diagnosis for this Request:**		
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature		Date	

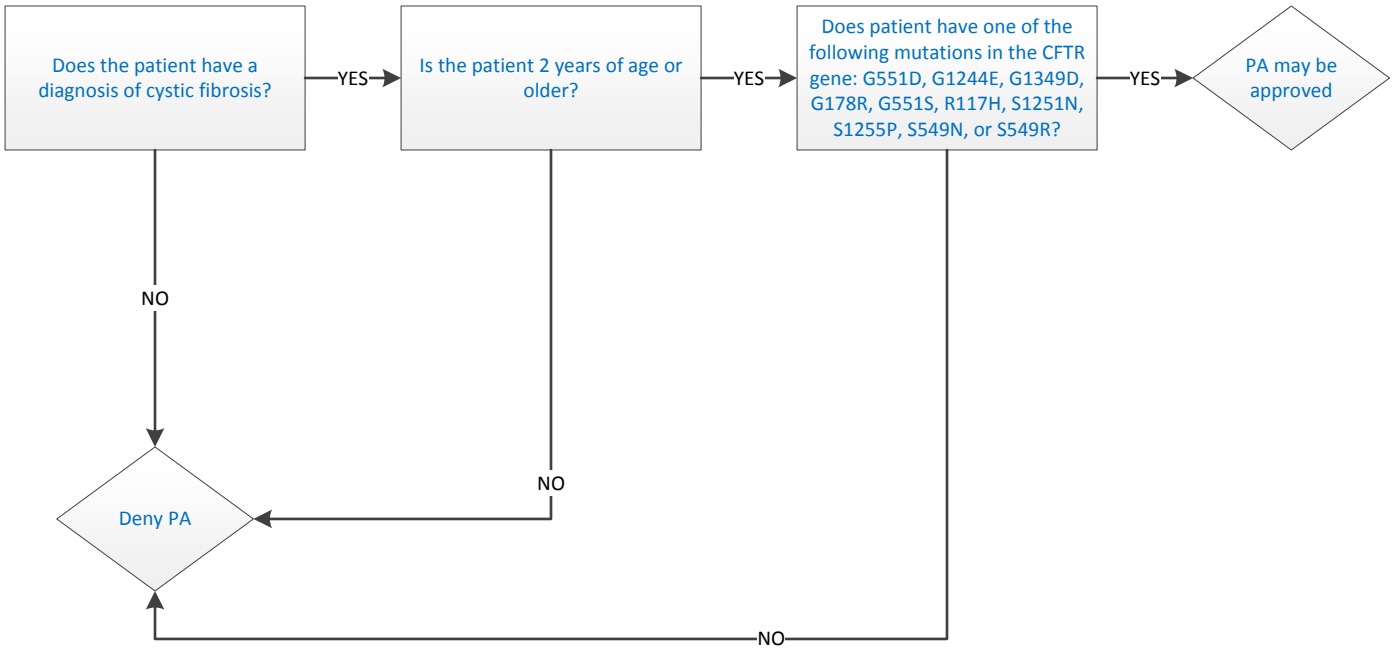
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Kalydeco Authorization Algorithm



KAPVAY PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Kapvay must meet the following criteria:

- **Patient must first try clonidine**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Presciber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ KAPVAY	**Diagnosis for this Request:**		
Failed Therapy (dose and frequency): □	**Start Date:** **End Date:**		
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature		Date	

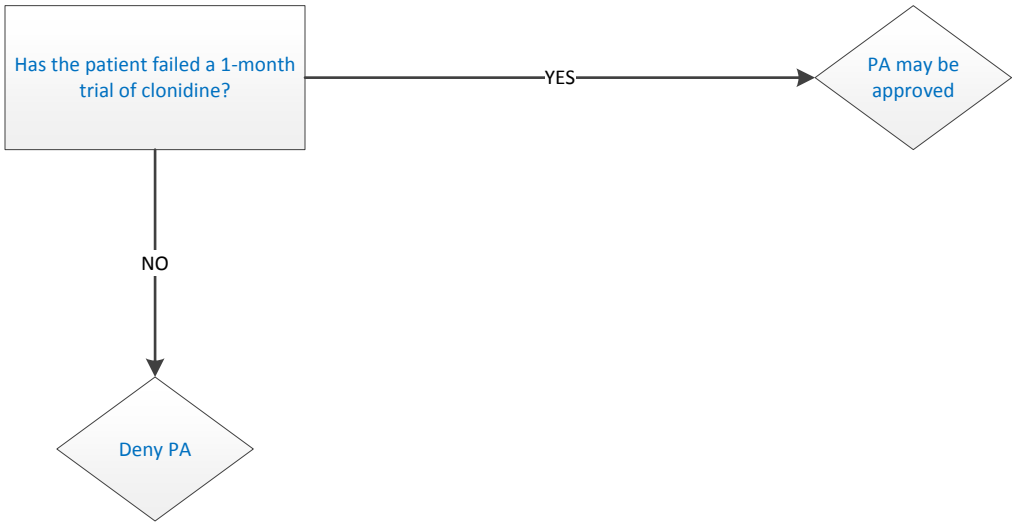
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Kapvay Authorization Algorithm



KETEK PA FORM

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

health information designs

Prior Authorization Vendor for ND Medicaid

- ND Medicaid will cover Ketek with a diagnosis of community-acquired pneumonia (of mild to moderate severity) due to Streptococcus pneumoniae for patients 18 years and older.
- ND Medicaid will cover Ketek for patients with an allergy to fluoroquinolones or tetracyclines.

Part I: TO BE COMPLETED BY PRESCRIBER

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of Birth: / /	
PRESCRIBER NAME:	PRESCRIBER NPI:
Address:	Phone: ( )
City:	FAX: ( )
State: Zip:	

REQUESTED DRUG: □ **KETEK**	**Requested Dosage:** (must be completed)

Qualifications for coverage:

□ Community acquired pneumonia (of mild to moderate severity) due to Streptococcus pneumoniae, (including multi-drug resistant isolates, Haemophilus influenzae, Moraxella catarrhalis, Chlamydophila pneumoniae, or Mycoplasma pneumoniae) for patients 18 years and older.

Does the patient have myasthenia gravis?

Does the patient have any other antibiotic use in the last 3 months?

□ Please list fluoroquinolone or tetracycline that patient is allergic to: _____

□ *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 recipient.*

Prescriber Signature: Date:

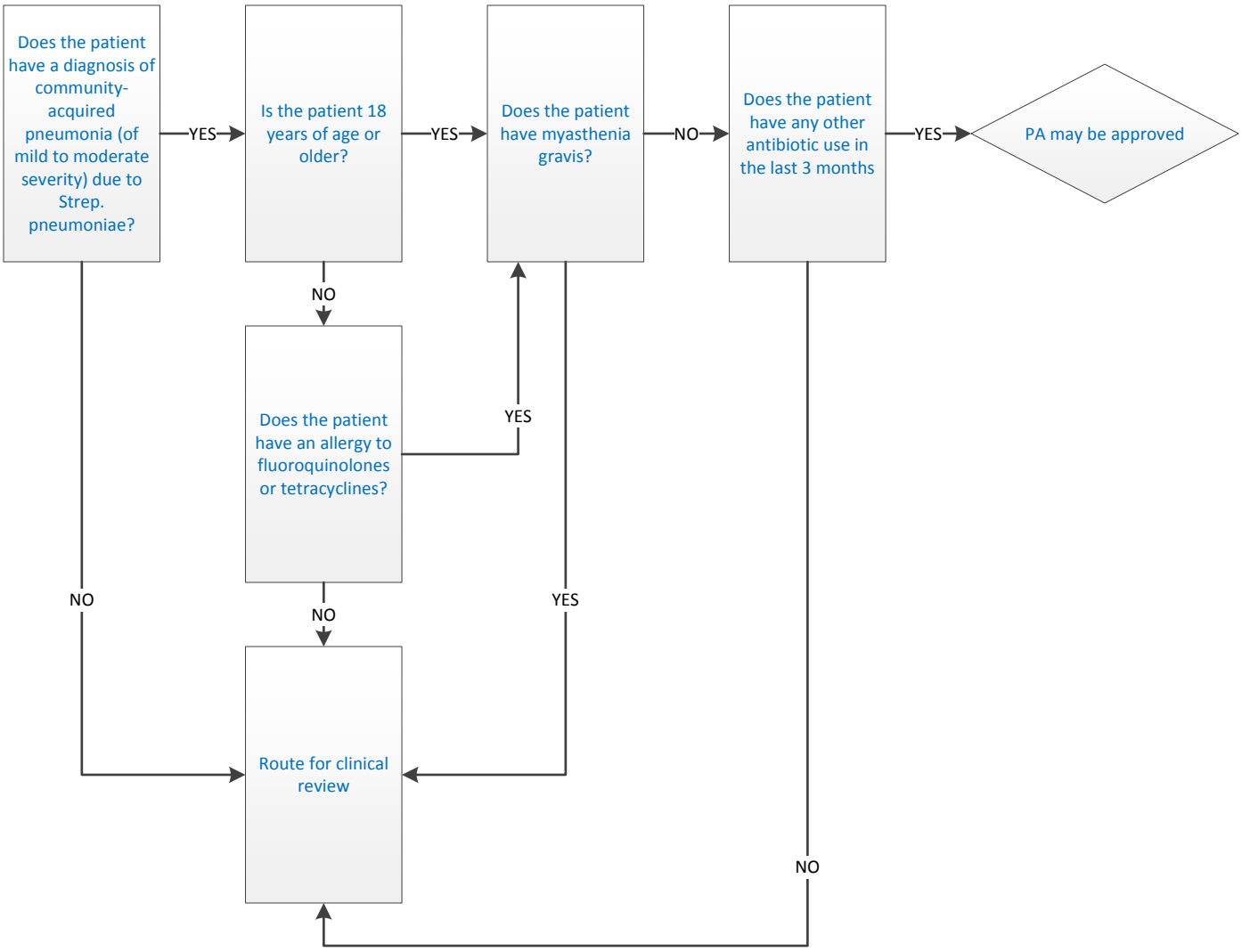
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Part III: FOR OFFICIAL USE ONLY

Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	

North Dakota Department of Human Services
Ketek Authorization Algorithm



KUVAN PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Kuvan must meet the following criteria:

- **Patient must have hyperphenalaninemia.**

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ KUVAN	**PHE level:**	**Diagnosis for this Request:**	**Patient's weight:**

Has the patient been known to have two null mutations in TRANS?	□ **YES**	□ **NO**
Are baseline PHE levels attached?	□ **YES**	□ **NO**
Is patient of child-bearing potential?	□ **YES**	□ **NO**
Is this a renewal request?	□ **YES**	□ **NO**

□ *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 recipient.*

Prescriber (or Staff) / Pharmacy Signature	Date

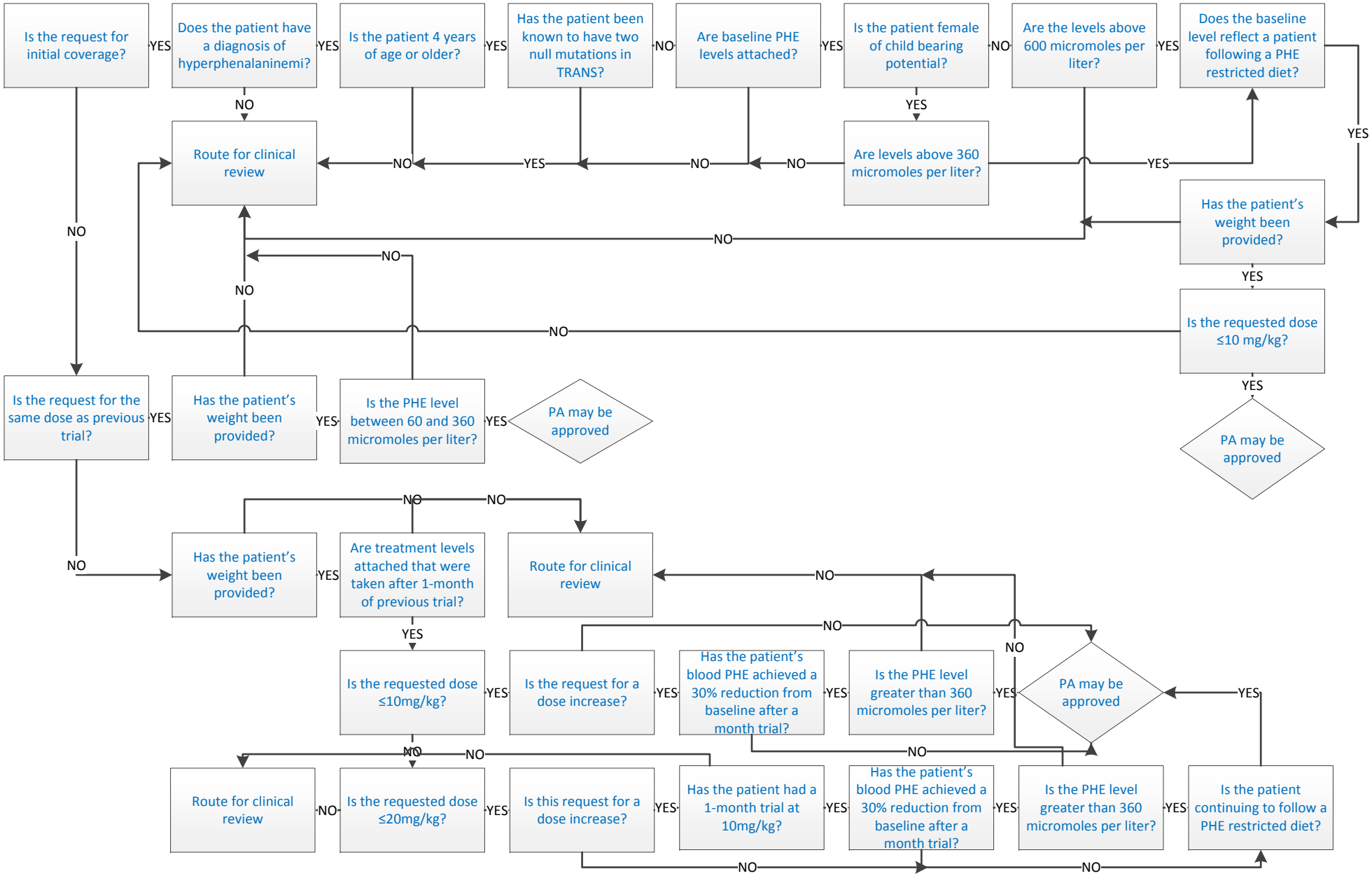
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Kuvan Authorization Algorithm



LEMTRADA PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Lemtrada must meet the following criteria:

- **Patient must have a confirmed diagnosis of multiple sclerosis.**
- **Requires step therapy. See Lemtrada criteria for more information.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ LEMTRADA	**FDA approved indication for this request:**		

• **Has patient experienced a reduction in relapse rate? (renewal requests)**	□ YES	□ NO
• **Is the patient experiencing early aggressive disease? (>=2 relapses in the year and >= 1 Cadolinium (Cd)+ lesion)?**	□ YES	□ NO
• **Does the patient have VZV antibodies/vaccination or history of varicella?**	□ YES	□ NO
• **Does the patient have appropriate SCr levels?**	□ YES	□ NO
• **Does the patient have appropriate urinalysis with urine cell counts?**	□ YES	□ NO
• **Has the patient had thyroid function tests?**	□ YES	□ NO
• **Has the patient had a TB test?**	□ YES	□ NO

List all failed medications:

Prescriber (or Staff) / Pharmacy Signature	Date

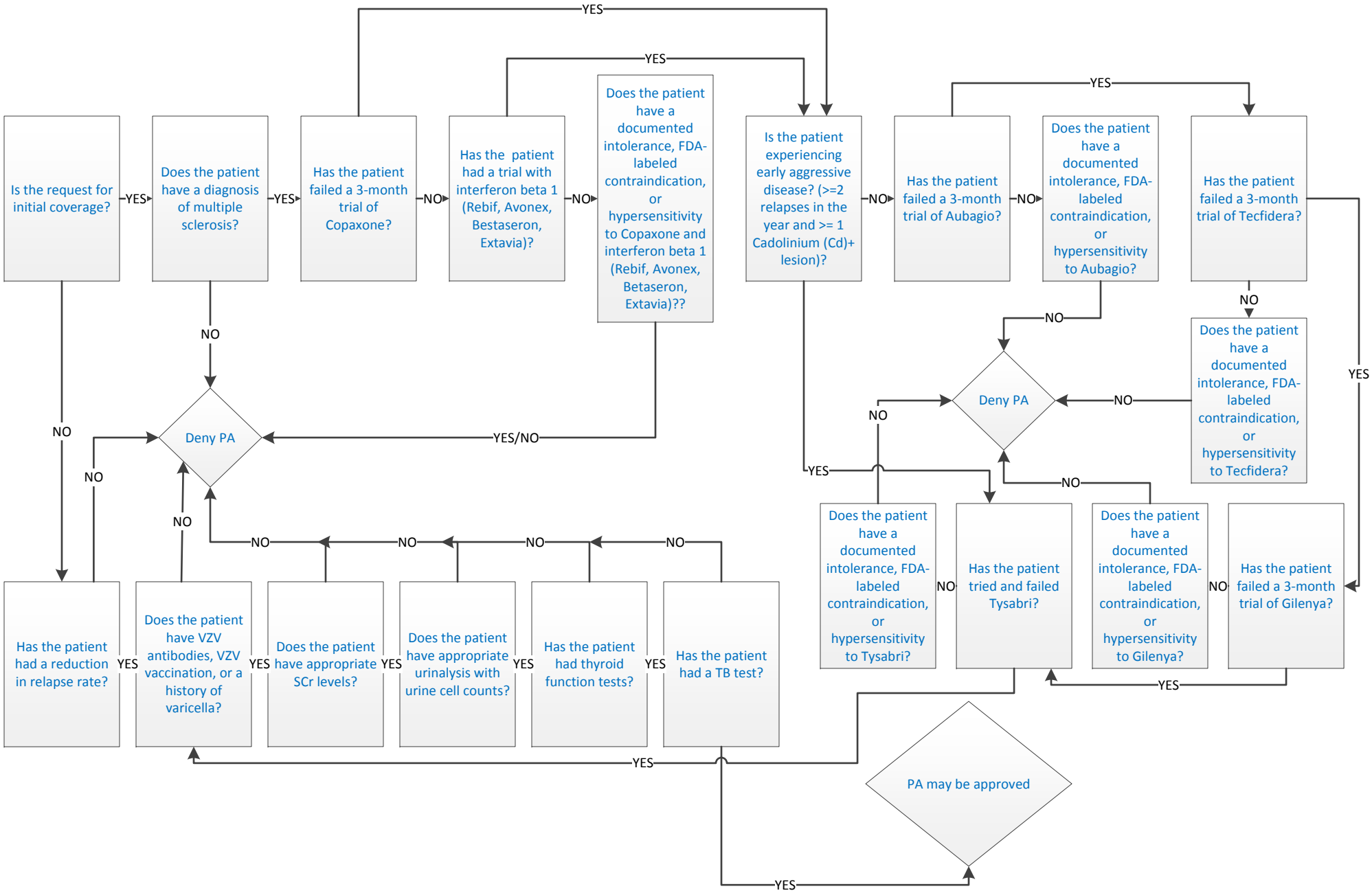
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Lemtrada Authorization Algorithm



LORZONE PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Lorzone must meet the following criteria:

- **Patient must first try chlorzoxazone**

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ LORZONE	**Diagnosis for this Request:**		
Failed Therapy (dose and frequency): □ CHLORZOXAZONE	**Start Date:** **End Date:**		
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature		Date	

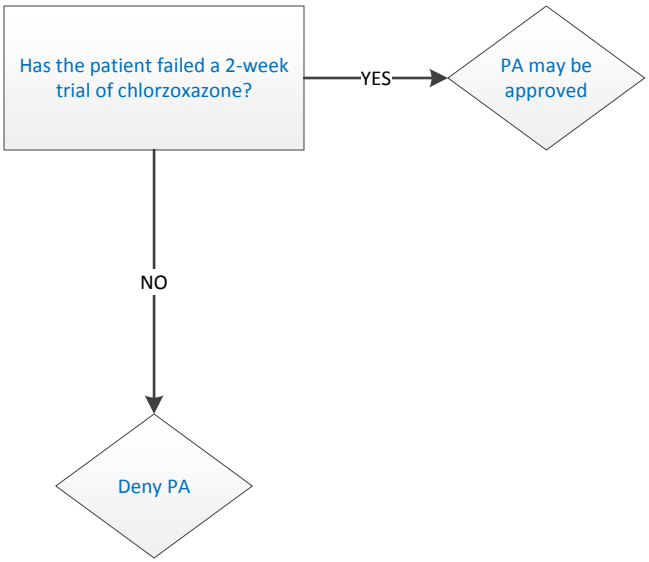
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Lorzone Authorization Algorithm



LUZU
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Luzu must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Patient must be 18 years of age or older.**
- **Patient must have documented history of failure of two topical antifungal agents (clotrimazole, econazole) and two oral antifungal agents (terbinafine, fluconazole, itraconazole).**

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ LUZU	**Diagnosis for this Request:**
Failed Therapy: **1.** **2.** **3.** **4.**	**Start Date:** **End Date:** **1.** **2.** **3.** **4.**
□ *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 recipient.*	
Prescriber (or Staff) / Pharmacy Signature	Date

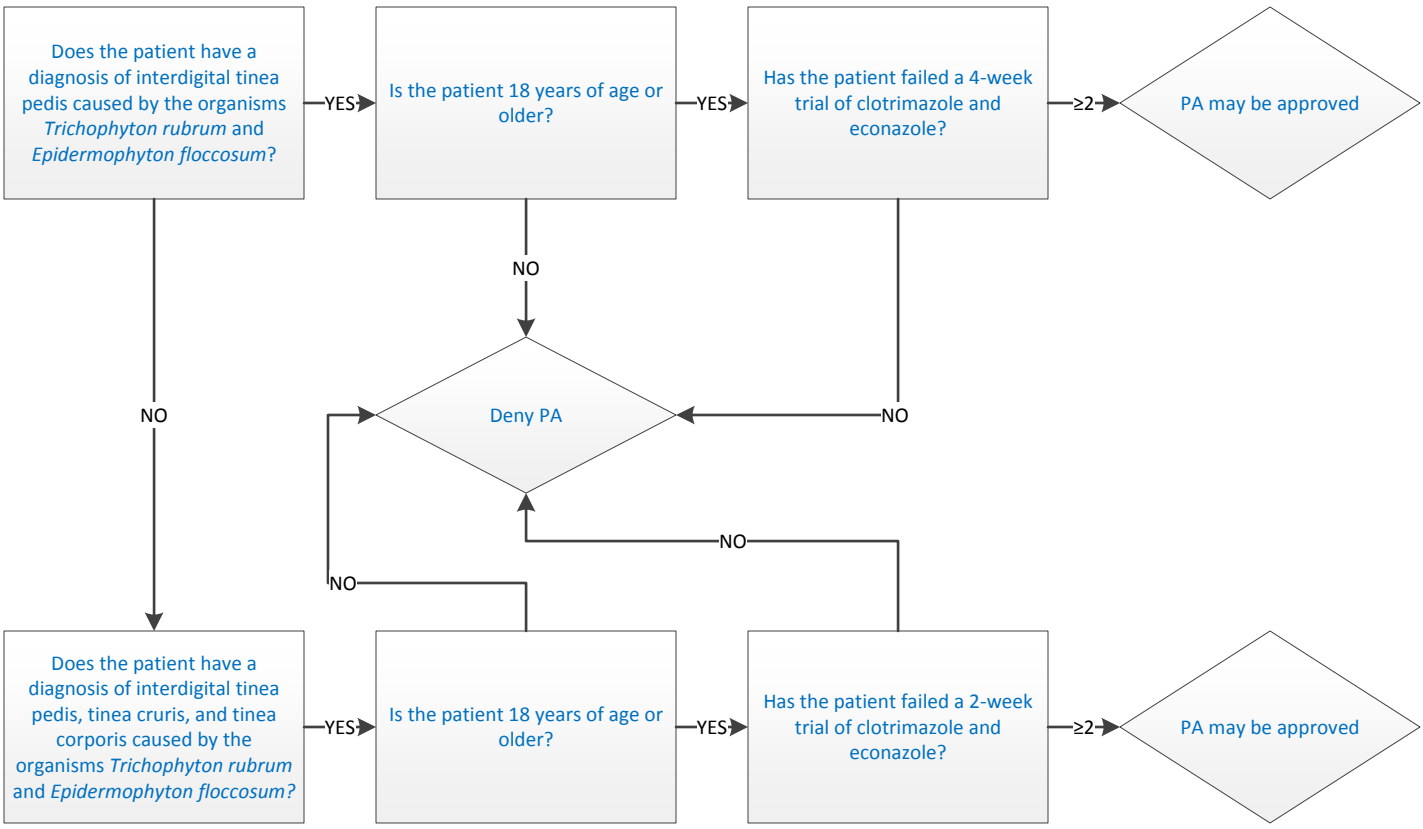
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Luzu Authorization Algorithm



MEDICATIONS > $3,000
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 medications that cost >$3,000 must meet the following criteria:

- **Patient must have an FDA approved indication for the medication requested.**
- **May be subject to additional criteria. See PA criteria for complete details.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ PROCYSBI □ RAVICTI □ CHOLBAM □ JUXTAPID □ KYNAMRO □ ARCALYST □ NATPARA □ QUTENZA	**FDA approved indication for this request:**		
Physician Signature		Date	

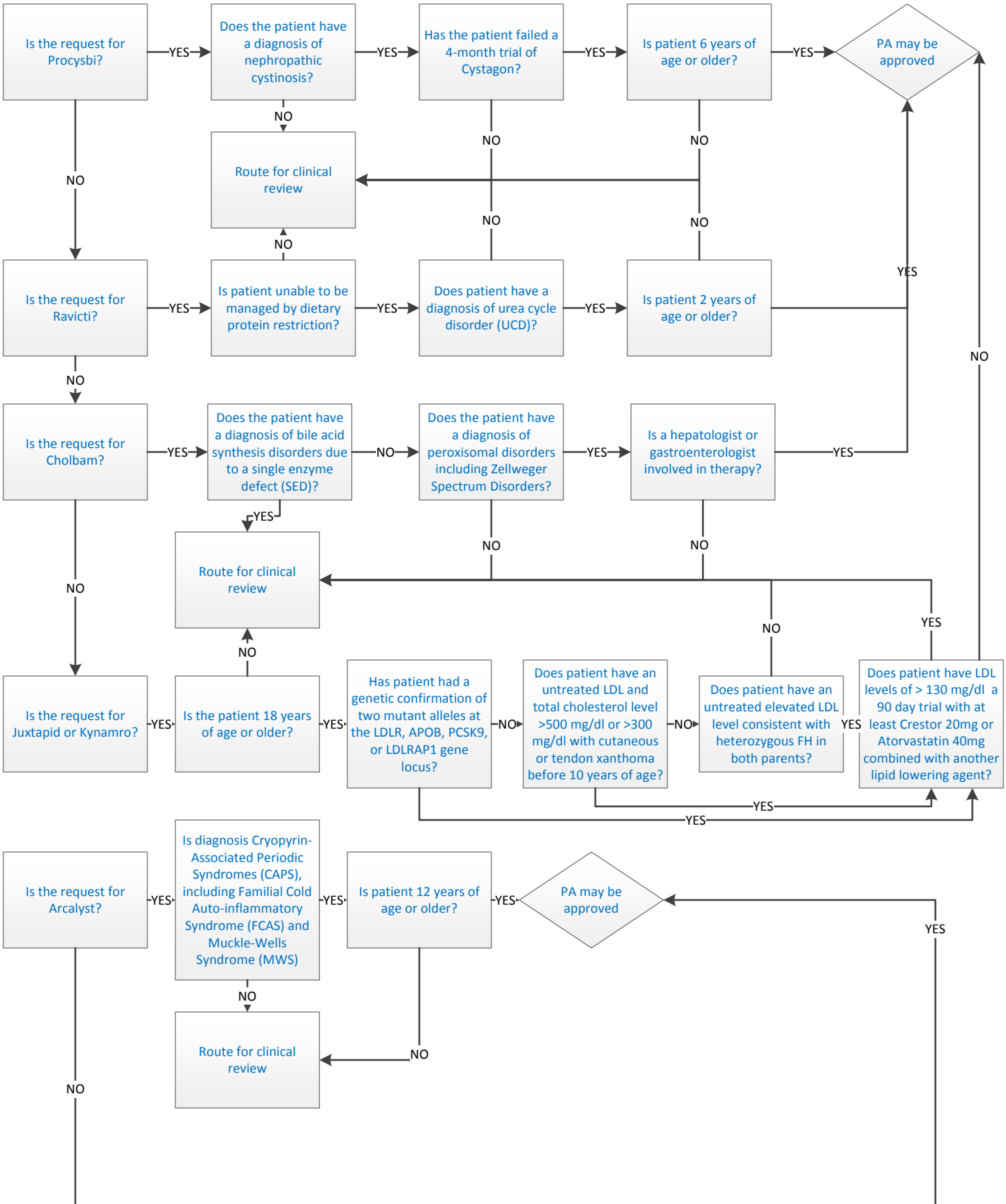
Part II: TO BE COMPLETED BY PHARMACY

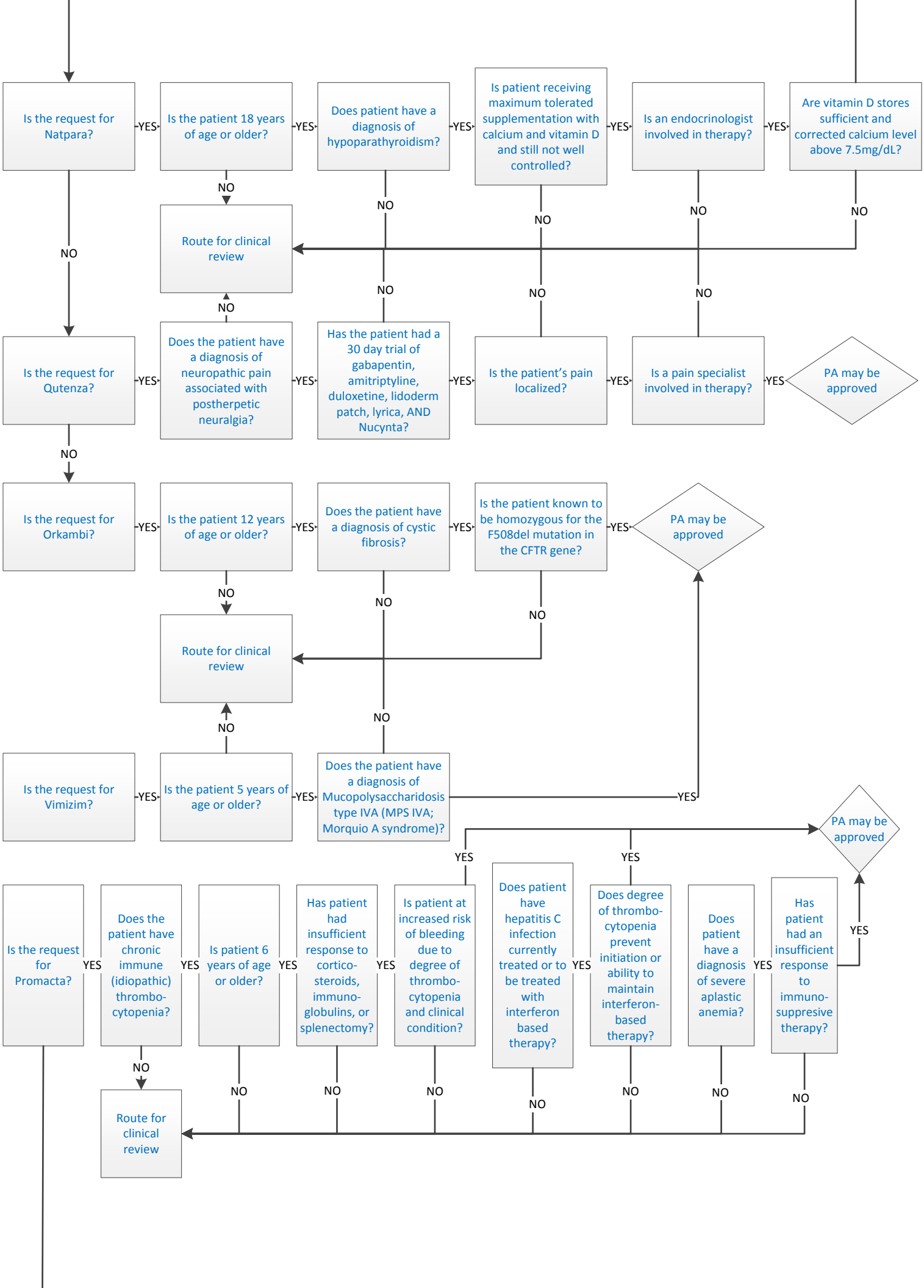
PHARMACY NAME (REQUIRED)			ND MEDICAID PROVIDER NUMBER (REQUIRED)
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC # (REQUIRED)

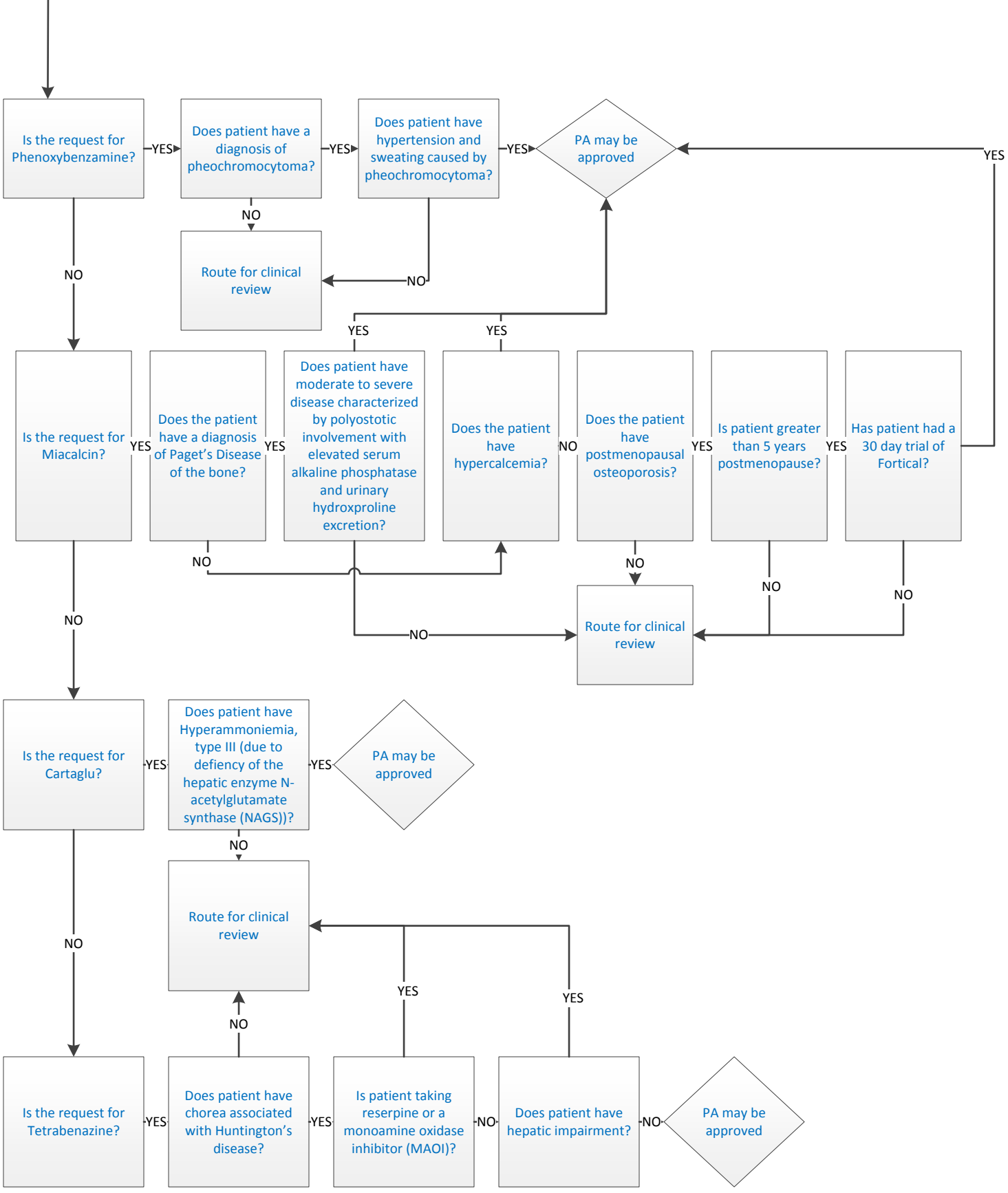
Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Medications > $3,000 Authorization Algorithm




Is the request for Natpara?
YES
Is the patient 18 years of age or older?
YES
Does patient have a diagnosis of hypoparathyroidism?
YES
Is patient receiving maximum tolerated supplementation with calcium and vitamin D and still not well controlled?
YES
Is an endocrinologist involved in therapy?
YES
Are vitamin D stores sufficient and corrected calcium level above 7.5mg/dL?
NO
NO
NO
NO
NO
NO
Route for clinical review
NO
Is the request for Qutenza?
YES
Does the patient have a diagnosis of neuropathic pain associated with postherpetic neuralgia?
YES
Has the patient had a 30 day trial of gabapentin, amitriptyline, duloxetine, lidoderm patch, lyrica, AND Nucynta?
YES
Is the patient's pain localized?
YES
Is a pain specialist involved in therapy?
YES
PA may be approved
NO
Is the request for Orkambi?
YES
Is the patient 12 years of age or older?
YES
Does the patient have a diagnosis of cystic fibrosis?
YES
Is the patient known to be homozygous for the F508del mutation in the CFTR gene?
YES
PA may be approved
NO
NO
NO
Route for clinical review
NO
NO
Is the request for Vimizim?
YES
Is the patient 5 years of age or older?
YES
Does the patient have a diagnosis of Mucopolysaccharidosis type IVA (MPS IVA; Morquio A syndrome)?
YES
PA may be approved
YES
YES
Is the request for Promacta?
YES
Does the patient have chronic immune (idiopathic) thrombo-cytopenia?
YES
Is patient 6 years of age or older?
YES
Has patient had insufficient response to cortico-steroids, immuno-globulins, or splenectomy?
YES
Is patient at increased risk of bleeding due to degree of thrombo-cytopenia and clinical condition?
YES
Does patient have hepatitis C infection currently treated or to be treated with interferon based therapy?
YES
Does degree of thrombo-cytopenia prevent initiation or ability to maintain interferon-based therapy?
YES
Does patient have a diagnosis of severe aplastic anemia?
YES
Has patient had an insufficient response to immuno-suppresive therapy?
YES
NO
NO
NO
NO
NO
NO
NO
NO
Route for clinical review


Is the request for Phenoxybenzamine?
YES
Does patient have a diagnosis of pheochromocytoma?
YES
Does patient have hypertension and sweating caused by pheochromocytoma?
YES
PA may be approved
YES
NO
Route for clinical review
NO
NO
YES
YES
Is the request for Miacalcin?
YES
Does the patient have a diagnosis of Paget's Disease of the bone?
YES
Does patient have moderate to severe disease characterized by polyostotic involvement with elevated serum alkaline phosphatase and urinary hydroxproline excretion?
Does the patient have hypercalcemia?
NO
Does the patient have postmenopausal osteoporosis?
YES
Is patient greater than 5 years postmenopause?
YES
Has patient had a 30 day trial of Fortical?
NO
NO
NO
NO
NO
Route for clinical review
Is the request for Cartaglu?
YES
Does patient have Hyperammoniemia, type III (due to defiency of the hepatic enzyme N-acetylglutamate synthase (NAGS))?
YES
PA may be approved
NO
Route for clinical review
NO
YES
YES
NO
Is the request for Tetrabenazine?
YES
Does patient have chorea associated with Huntington's disease?
YES
Is patient taking reserpine or a monoamine oxidase inhibitor (MAOI)?
NO
Does patient have hepatic impairment?
NO
PA may be approved

METOZOLV ODT PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Metozolv must meet the following criteria:

- **Patient must try metoclopramide.**

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ METOZOLV		**Diagnosis for this request:**	
□ **FAILED METOCLOPRAMIDE THERAPY**	**START DATE**	**END DATE**	**DOSE**
□ *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 recipient.*			
Prescriber (or Staff) / Signature		Date	

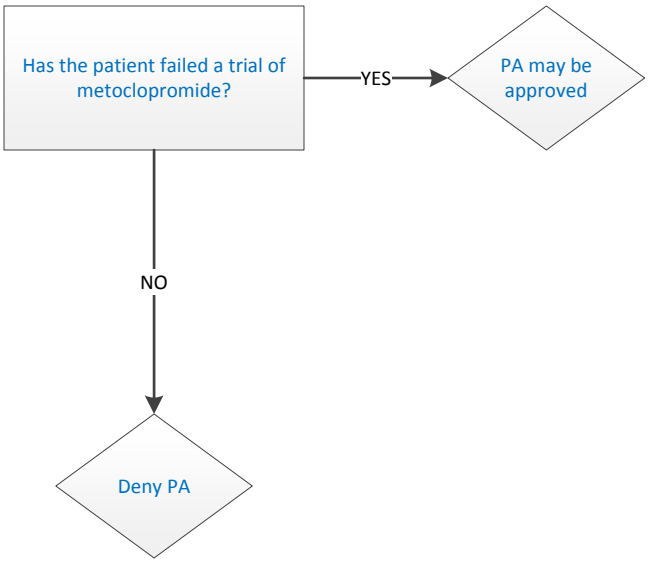
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Metozolv Authorization Algorithm



MIFEPREX
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Mifeprex must meet the following criteria:

- **Patient must have an FDA approved indication for the medication requested.**
- **Prescriber must provide signed written statement. See criteria for more information.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		

- **Is the patient terminating a pregnancy before 49 days of pregnancy? □ YES □ NO**
- **Is the pregnancy resulting from an act of rape or incest? □ YES □ NO If yes, fill out section 1. If no, fill out section 2:**

Section 1:

- **Has the appropriate law enforcement agency been notified, or agency authorized to receive child abuse and neglect reports? □ YES □ NO**
  If yes, has the provider provided a signed written statement indicating that the rape or act of incest has been reported and to whom the report was made?
  If no, has the provider provided signed written verification that in the provider's professional judgment, the woman's pregnancy resulted from rape or incest? □ YES □ NO
  Has the provider provided a written statement signed by the recipient that her current pregnancy resulted from an act of rape or incest? □ YES □ NO

Section 2:

- **Does the woman suffer from a physical disorder that would place the woman in danger of death unless abortion is performed? □ YES □ NO**
- **Has the treating provider provided a signed written statement that, in the provider's professional judgment, the life of a woman would be endangered if the fetus were carried to term? □ YES □ NO**
- **Does the statement contain the reasons why the physician believes the life of the woman would be in danger if the fetus were carried to term? □ YES □ NO**

Physician Signature	Date

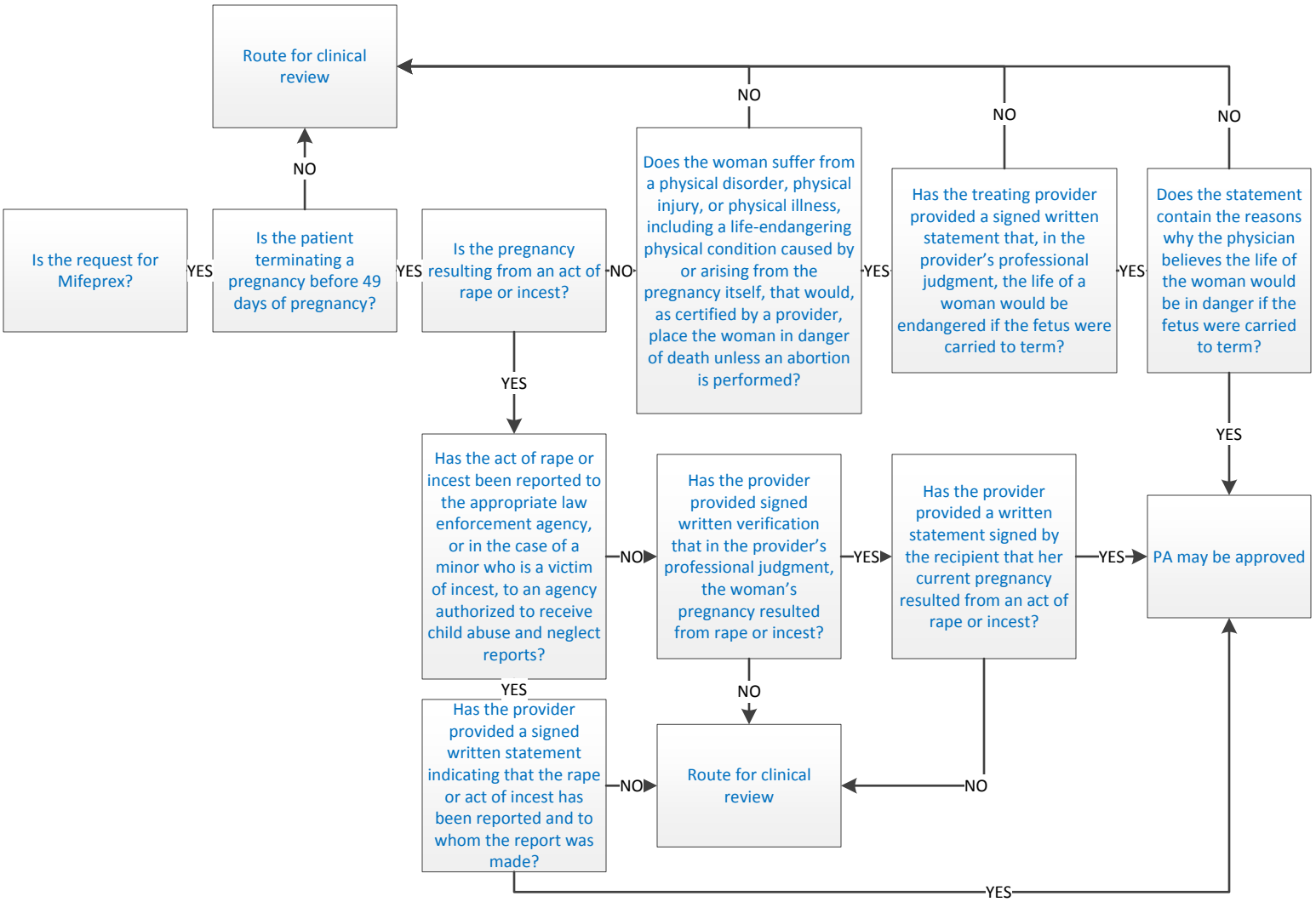
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Mifeprex Authorization Algorithm



MOXATAG PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Moxatag must submit documentation of allergies or show a history of intolerable side effects to the inactive ingredients in regular-release amoxicillin.

- Regular-release amoxicillin does not require a prior authorization.

Part I: TO BE COMPLETED BY PHYSICIAN

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 : □ MOXATAG	**Dosage**
Qualifications for coverage:	
□ Allergic/intolerable side effects to inactive ingredients of regular-release amoxicillin. Name of inactive ingredient: _____	Diagnosis for this request:
□ *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 recipient.*	
Prescriber (or Staff) / Pharmacy Signature	Date

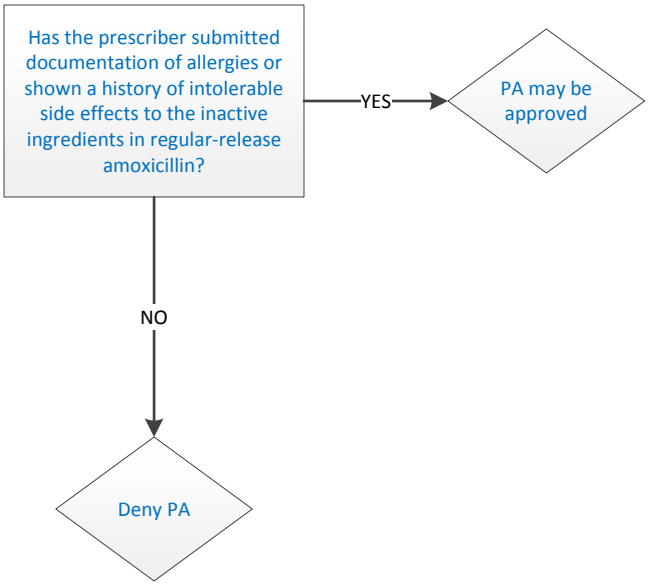
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Moxatag Authorization Algorithm



NARCOTICS PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 a narcotic must meet the following criteria:

- **Documented failure of a 30-day trial of a generic narcotic.**
- **Requires step therapy. See narcotic criteria for more information.**

Part I: TO BE COMPLETED BY PHYSICIAN

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: **Diagnosis:** **Does the patient have cancer pain?**

Has patient required daily use of opioids for at least 90 days?

FAILED THERAPY	**START DATE**	**END DATE**	**DOSE**	**FREQUENCY**

Prescriber (or State) / Pharmacy Signature	Date

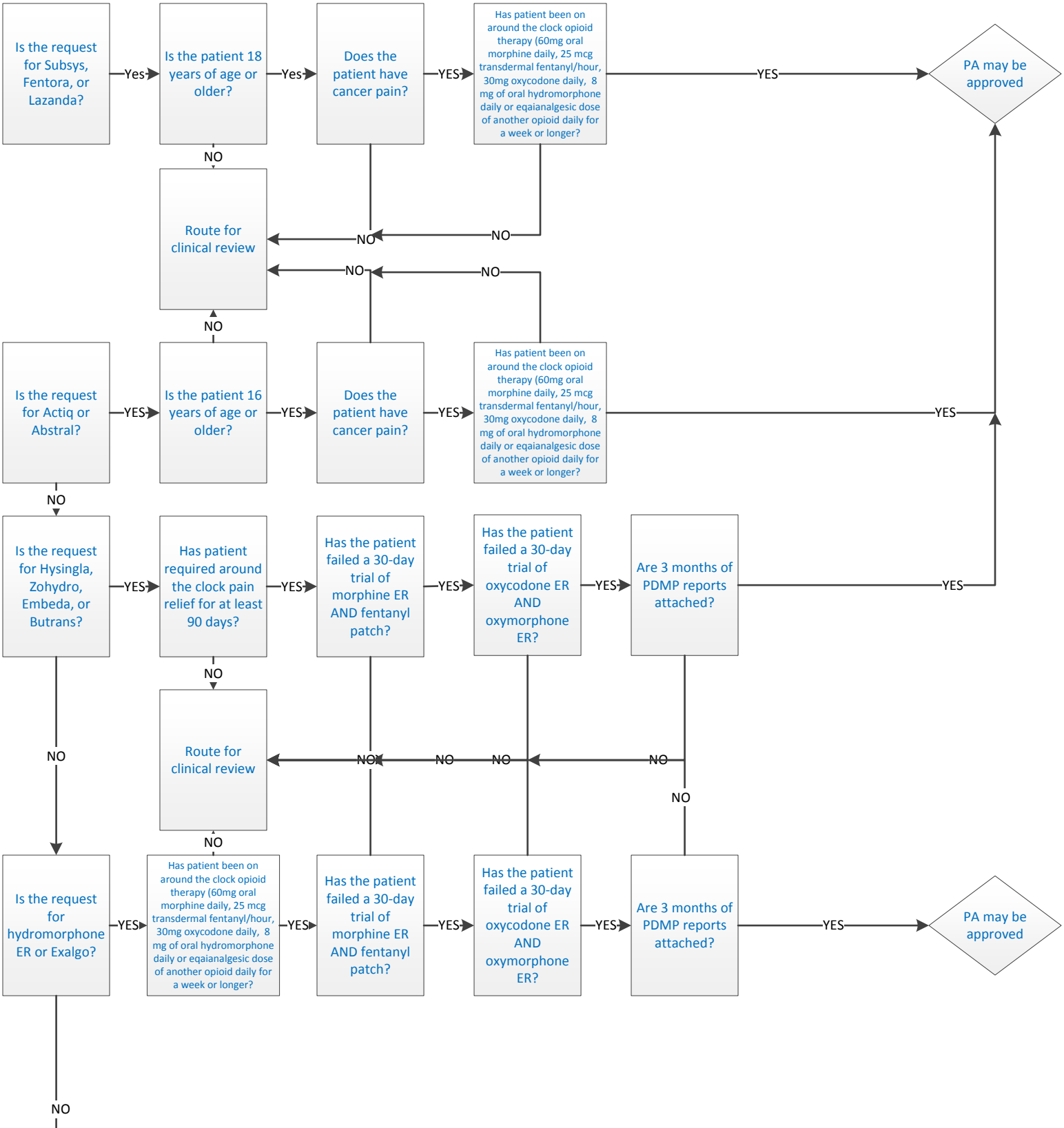
Part II: TO BE COMPLETED BY PHARMACY

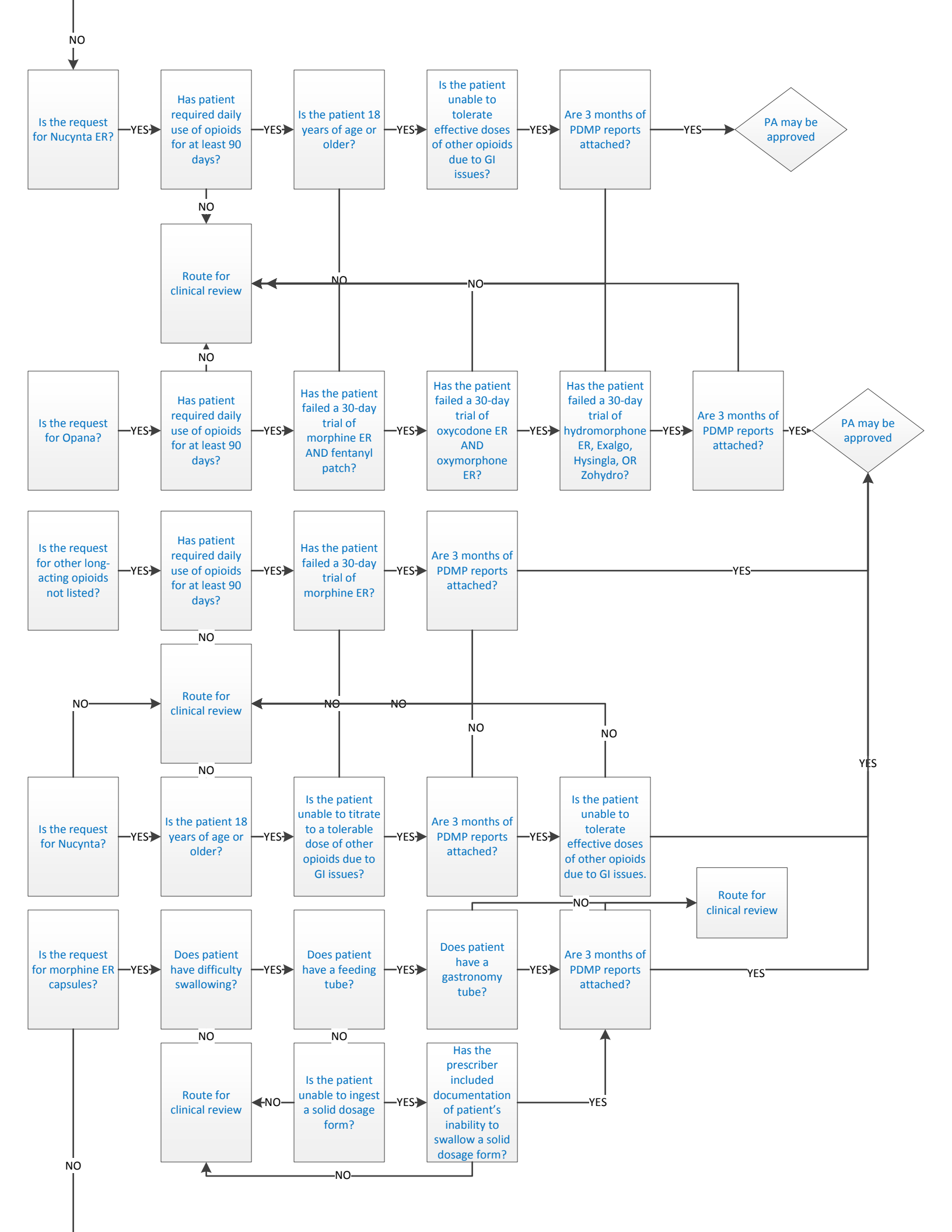
PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

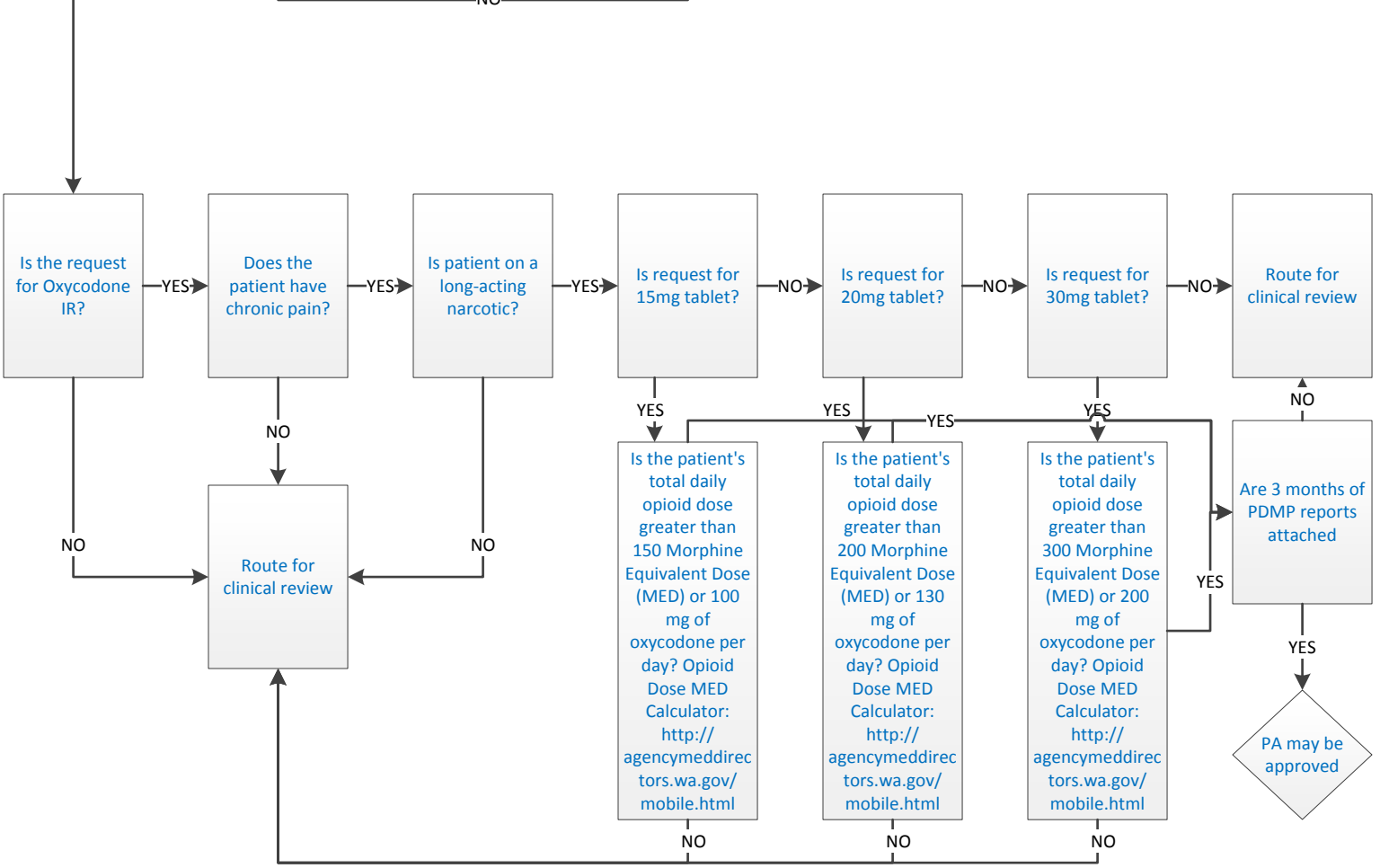
Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Narcotics Authorization Algorithm




NO
Is the request for Nucynta ER?
YES
Has patient required daily use of opioids for at least 90 days?
YES
Is the patient 18 years of age or older?
YES
Is the patient unable to tolerate effective doses of other opioids due to GI issues?
YES
Are 3 months of PDMP reports attached?
YES
PA may be approved
NO
Route for clinical review
NO
NO
NO
Is the request for Opana?
YES
Has patient required daily use of opioids for at least 90 days?
YES
Has the patient failed a 30-day trial of morphine ER AND fentanyl patch?
YES
Has the patient failed a 30-day trial of oxycodone ER AND oxymorphone ER?
YES
Has the patient failed a 30-day trial of hydromorphone ER, Exalgo, Hysingla, OR Zohydro?
YES
Are 3 months of PDMP reports attached?
YES
PA may be approved
Is the request for other long-acting opioids not listed?
YES
Has patient required daily use of opioids for at least 90 days?
YES
Has the patient failed a 30-day trial of morphine ER?
YES
Are 3 months of PDMP reports attached?
YES
NO
Route for clinical review
NO
NO
NO
NO
NO
Is the request for Nucynta?
YES
Is the patient 18 years of age or older?
YES
Is the patient unable to titrate to a tolerable dose of other opioids due to GI issues?
YES
Are 3 months of PDMP reports attached?
YES
Is the patient unable to tolerate effective doses of other opioids due to GI issues.
YES
NO
Route for clinical review
Is the request for morphine ER capsules?
YES
Does patient have difficulty swallowing?
YES
Does patient have a feeding tube?
YES
Does patient have a gastronomy tube?
YES
Are 3 months of PDMP reports attached?
YES
NO
NO
Route for clinical review
NO
Is the patient unable to ingest a solid dosage form?
YES
Has the prescriber included documentation of patient's inability to swallow a solid dosage form?
YES
NO
NO


Is the request for Oxycodone IR?
YES
Does the patient have chronic pain?
YES
Is patient on a long-acting narcotic?
YES
Is request for 15mg tablet?
NO
Is request for 20mg tablet?
NO
Is request for 30mg tablet?
NO
Route for clinical review
NO
NO
Route for clinical review
NO
YES
Is the patient's total daily opioid dose greater than 150 Morphine Equivalent Dose (MED) or 100 mg of oxycodone per day? Opioid Dose MED Calculator: http://agencymeddirectors.wa.gov/mobile.html
YES
Is the patient's total daily opioid dose greater than 200 Morphine Equivalent Dose (MED) or 130 mg of oxycodone per day? Opioid Dose MED Calculator: http://agencymeddirectors.wa.gov/mobile.html
YES
Is the patient's total daily opioid dose greater than 300 Morphine Equivalent Dose (MED) or 200 mg of oxycodone per day? Opioid Dose MED Calculator: http://agencymeddirectors.wa.gov/mobile.html
YES
Are 3 months of PDMP reports attached
NO
YES
PA may be approved
NO
NO
NO

health information designs

Prior Authorization Vendor for ND Medicaid

Narcotics/APAP Prior Authorization

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 narcotics containing acetaminophen doses greater than 325mg must use hydrocodone/acetaminophen 5/325-10/325 or oxycodone acetaminophen 5/325-10/325.

- ***FDA is requesting that drug manufacturers limit the amount of acetaminophen in prescription drug products to 325mg per dosage unit.***
- ***Higher-dose formulations of hydrocodone/acetaminophen and oxycodone/acetaminophen should be phased out by 2014.***

Part I: TO BE COMPLETED BY PHYSICIAN

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:	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED THERAPY START DATE: END DATE:	DOSE: FREQUENCY:		
Prescriber (or Staff) / Pharmacy Signature		Date	

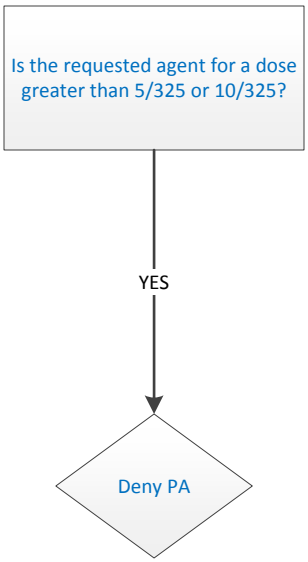
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Narcotics/APAP Authorization Algorithm



health information designs

Smoking Cessation Program

NDQuits

1-800-QUIT-NOW

Prior Authorization Vendor for ND Medicaid

North Dakota Medicaid has joined forces with the Department of Health to provide free, confidential, telephone-based cessation coaching to recipients interested in quitting tobacco. Beginning November 15, 2008, in order to receive smoking cessation products (patches, gum, lozenges, bupropion, or Chantix®), Medicaid recipients must be signed up with NDQuits (1-800-QUIT-NOW or 1-800-784-8669). Once a recipient is enrolled in coaching, they will work with their coach to determine which medications they wish to use. The complete process is described below:

1. Patient calls NDQuits and enrolls in coaching.
2. Coaches guide patient through quitting process.
3. Individualized treatment plan developed.
4. If medications are used, the patient will receive an enrollment letter which will include the NDQuit's standing orders for the specific medication(s).
5. The HID Prior Authorization form will be included with the letter
6. The client must contact their physician and obtain the prescription.
7. The patient, physician or pharmacy must fax the Prior Authorization form and enrollment letter to HID.
8. Patient takes prescription to pharmacy.
9. Pharmacy fills prescription and the claim is paid.

Patients will be limited to a 90 day supply of therapy for patches, gum, lozenges, and bupropion, every two years. Combination therapy with these medications is allowed.

Chantix is limited to the initial 12 weeks of therapy with an additional 12 weeks (24 consecutive weeks) allowed if the patient has continuously quit for a minimum of one month (since day 56 of therapy). The Chantix regimen will be allowed once every two years.

Prior authorizations will be entered based upon the recipient's Quit Date. This means that the approval date range will be sufficient to allow recipients to pick up medications at least one week prior to their Quit Date. Compliance will be an important aspect of the patient's success.

Please contact Health Information Designs, Inc. at (334) 502-3262 or toll free at 1-800-225-6998, with questions regarding the smoking cessation prior authorization process.

health information designs

Prior Authorization Vendor for ND Medicaid

Nexiclon Prior Authorization

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 Nexiclon must try and fail clonidine.
Note:

- ***Clonidine does not require PA***

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ **Nexiclon**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED CLONIDINE THERAPY START DATE: END DATE:	DOSE: FREQUENCY:		
Prescriber (or Staff) / Pharmacy Signature		Date	

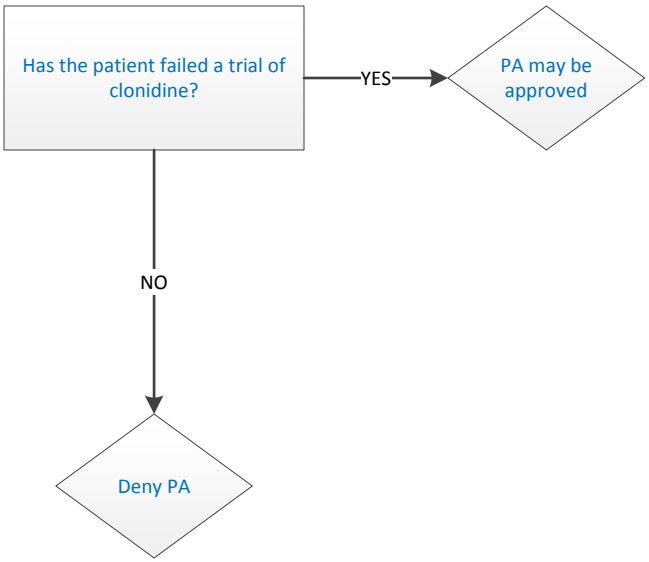
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Nexiclon Authorization Algorithm



health information designs

Nitroglycerin Lingual Spray Prior Authorization

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 patients receiving a new prescription for Nitrolingual Spray must meet the following criteria:

- *Patient must first try sublingual tablets*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

QUALIFICATIONS FOR COVERAGE:	
Requested Drug and Dosage: □ **Nitroglycerin Lingual Spray**	Diagnosis for this request:
Failed Therapy:	Start Date: End Date:
Prescriber (or Staff) / Pharmacy Signature	Date

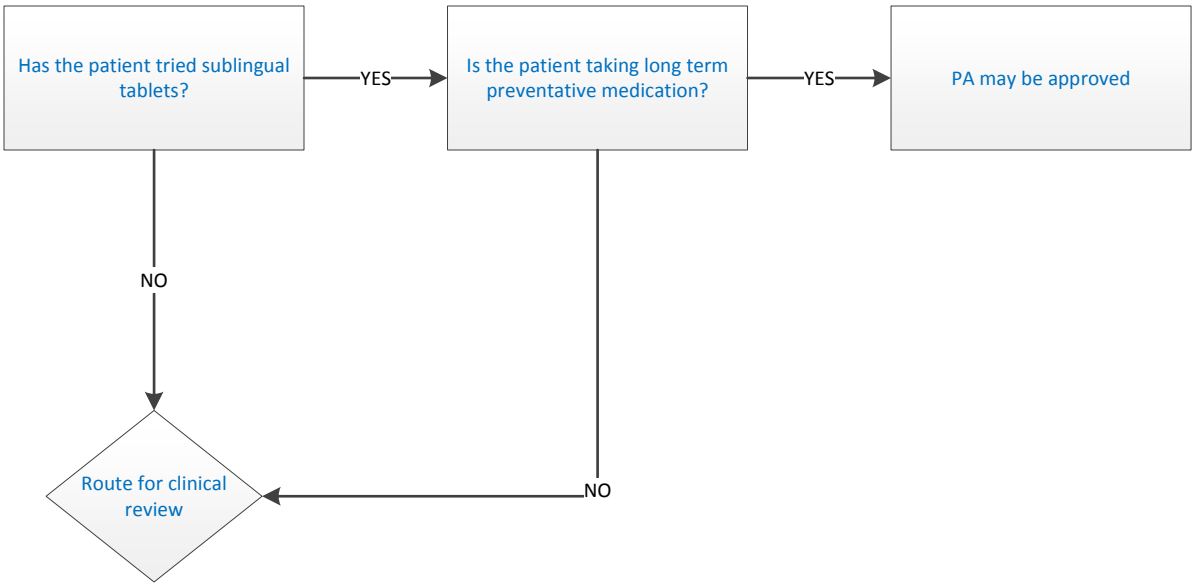
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Nitroglycerin Lingual Spray Authorization Algorithm



NORTHERA
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Northera must meet the following criteria:

- **Patient must have an FDA approved indication.**

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ NORTHERA	**Diagnosis for this Request:**		
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature		Date	

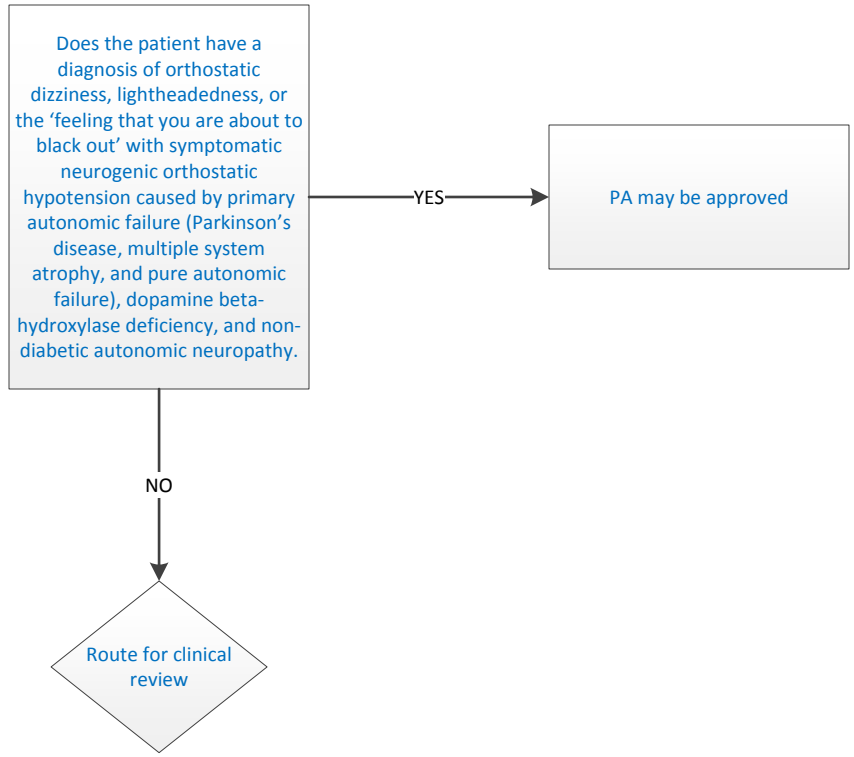
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Northera Authorization Algorithm



NOXAFIL
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Noxafil must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Patient must have documented history of failure of two agents (itraconazole, fluconazole) to receive Noxafil suspension for oropharyngeal candidiasis.**

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ NOXAFIL TABLET □ NOXAFIL SUSPENSION	**Diagnosis for this Request:**
Failed Therapy for Oropharyngeal Candidiasis (suspension only): **1.** **2.**	**Start Date:** **End Date:** **1.** **2.**
□ *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 recipient.*	
Prescriber (or Staff) / Pharmacy Signature	Date

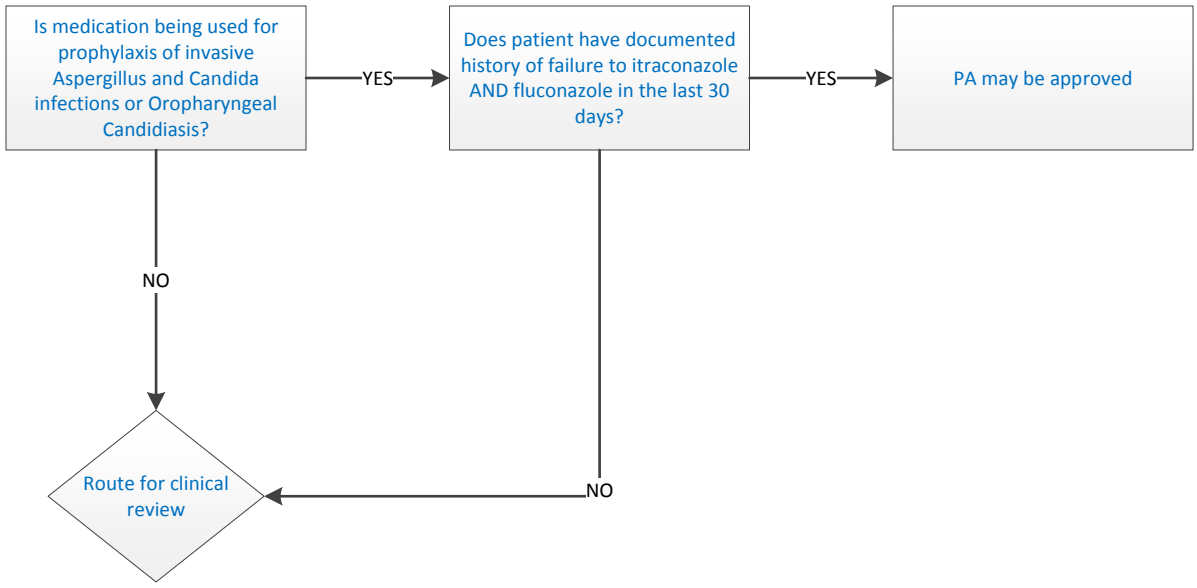
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Noxafil Authorization Algorithm



health information designs

Prior Authorization Vendor for ND Medicaid

NSAID/COX-II PA FORM

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

ND Medicaid requires that patients using NSAIDs or COX-II drugs must use a generic NSAID first line.

***Note: The PA will be approved if one of the following criteria is met:**

- **Failed two trials of prescribed oral NSAIDs to receive brand name oral NSAIDs**
- **Failed trial of Voltaren gel to receive brand name topical NSAIDs for inflammation**
- **Recipient is on warfarin or corticosteroid therapy**
- **Recipient has history of gastric or duodenal ulcer or has comorbidities of GI bleed, perforation or obstruction**
- **Recipient has history of endoscopically documented NSAID induced gastritis with GI bleed**
- **Solaraze will be covered for patients with a diagnosis of actinic keratoses**

Part I: TO BE COMPLETED BY PRESCRIBER

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:	**Diagnosis for this request:**	
□ Celebrex	□ Warfarin/Corticosteroid therapy	□ GI bleed, perforation or obstruction
□ Other _____	□ Gastric or duodenal ulcer	□ Endoscopically documented NSAID gastritis with GI Bleed
	□ Actinic keratoses **(Solaraze)**	

Qualifications for coverage:

Does patient have arthritis requiring long-term high dosage of NSAIDS?	□ YES	□NO
Is patient at high risk for mucosal injury?	□ YES	□NO
Is the patient taking aspirin at any dose?	□ YES	□NO
Is patient at risk of cardiovascular disease?	□ YES	□NO
Will prescriber continue to weigh GI benefits against CV risks and discontinue COX-II as soon as possible?	□ YES	□NO

□ Failed NSAID therapy	Start Date	End Date	Dose	Frequency
□ Failed NSAID therapy	Start Date	End Date	Dose	Frequency

□ *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 recipient.*

Prescriber (or Staff) / Pharmacy Signature	Date

Part II: TO BE COMPLETED BY PHARMACY

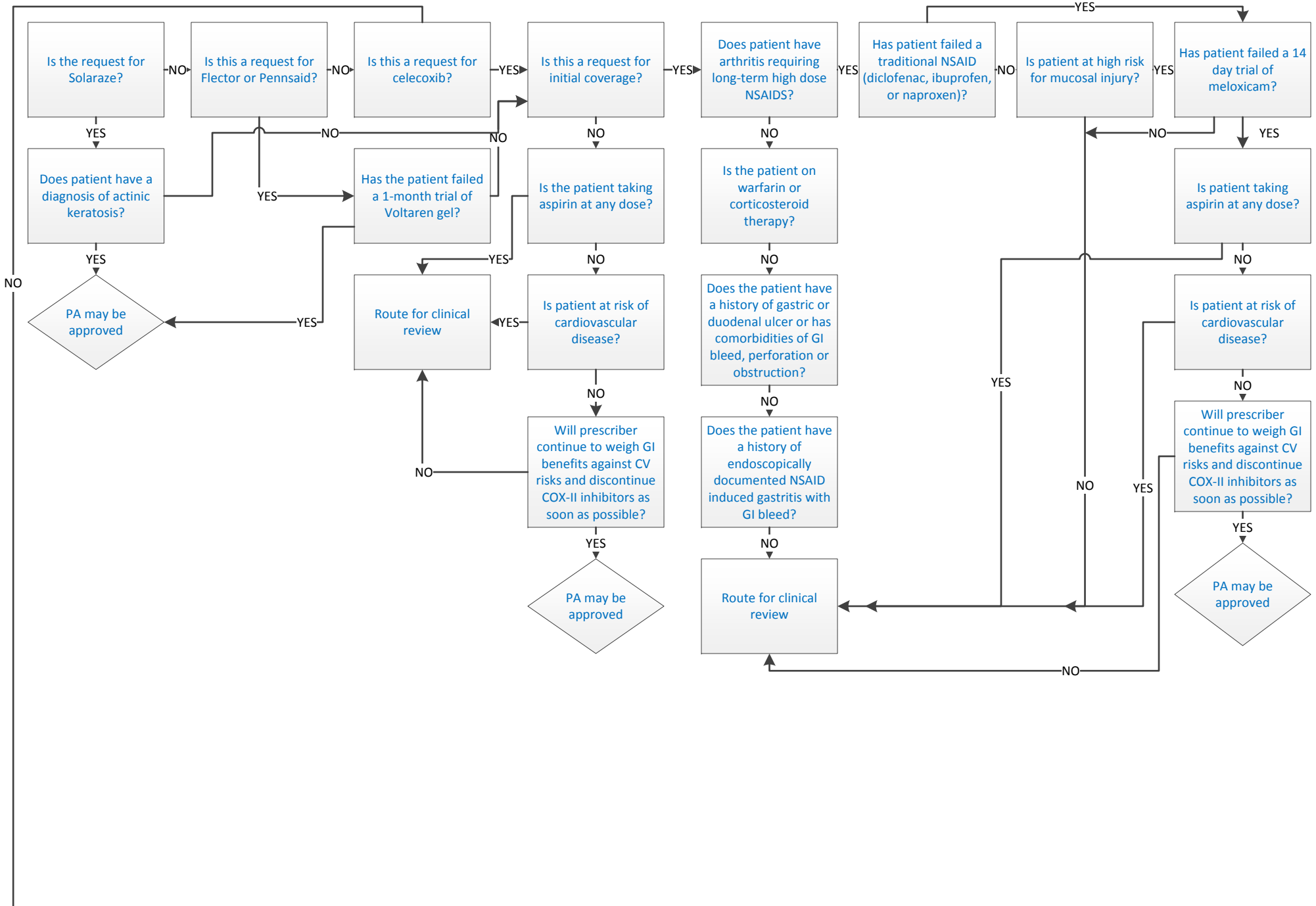
PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

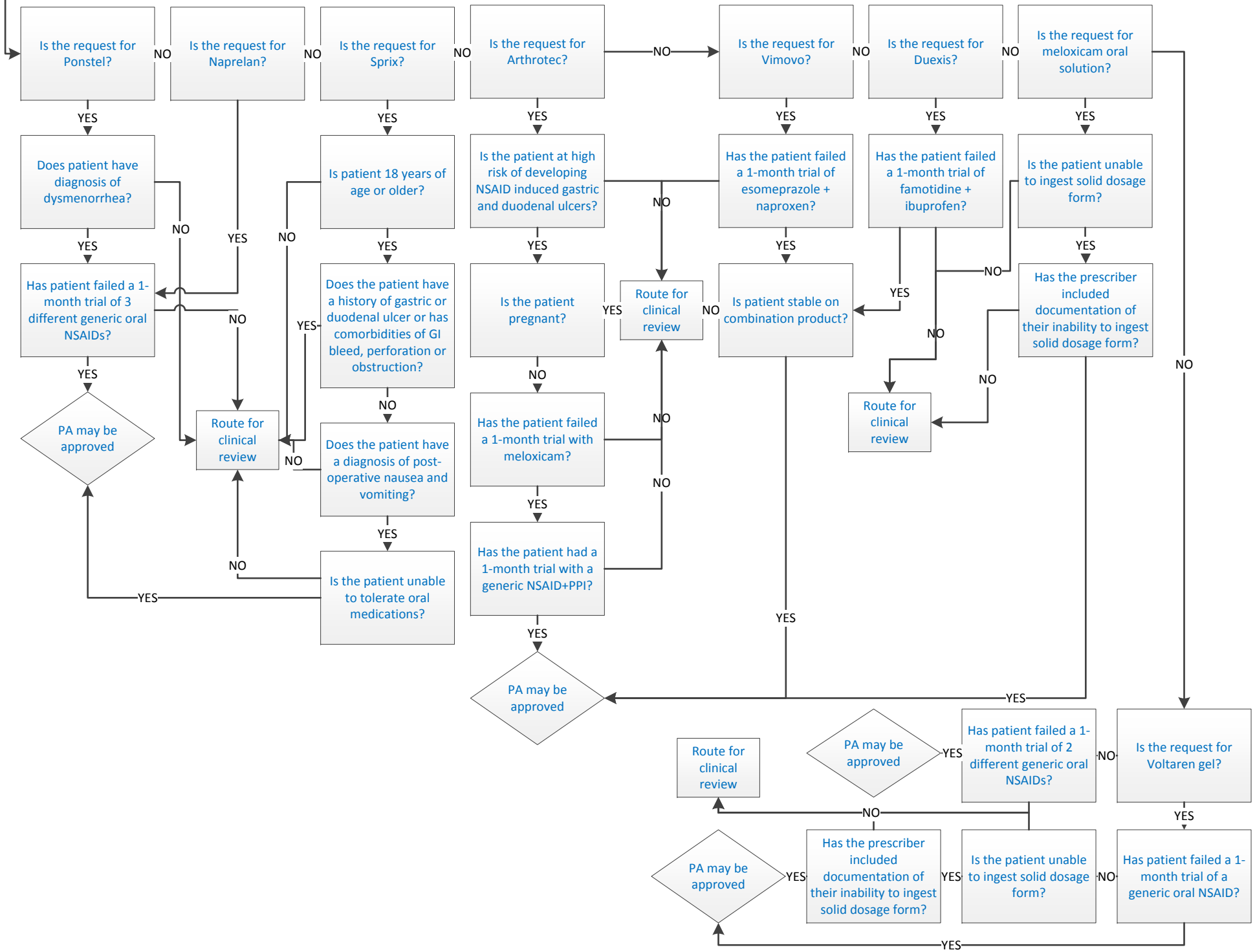
Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

Revised: 06/29/2015

North Dakota Department of Human Services
NSAID/COX-II Authorization Algorithm




Is the request for Ponstel?
NO
Is the request for Naprelan?
NO
Is the request for Sprix?
NO
Is the request for Arthrotec?
NO
Is the request for Vimovo?
NO
Is the request for Duexis?
NO
Is the request for meloxicam oral solution?
YES
Does patient have diagnosis of dysmenorrhea?
YES
Has patient failed a 1-month trial of 3 different generic oral NSAIDs?
YES
PA may be approved
NO
YES
Route for clinical review
Is patient 18 years of age or older?
YES
Does the patient have a history of gastric or duodenal ulcer or has comorbidities of GI bleed, perforation or obstruction?
NO
Does the patient have a diagnosis of post-operative nausea and vomiting?
YES
Is the patient unable to tolerate oral medications?
Is the patient at high risk of developing NSAID induced gastric and duodenal ulcers?
YES
Is the patient pregnant?
NO
Has the patient failed a 1-month trial with meloxicam?
YES
Has the patient had a 1-month trial with a generic NSAID+PPI?
Route for clinical review
Has the patient failed a 1-month trial of esomeprazole + naproxen?
YES
Is patient stable on combination product?
Has the patient failed a 1-month trial of famotidine + ibuprofen?
Is the patient unable to ingest solid dosage form?
Has the prescriber included documentation of their inability to ingest solid dosage form?
Route for clinical review
PA may be approved
Has patient failed a 1-month trial of 2 different generic oral NSAIDs?
Is the request for Voltaren gel?
Has the prescriber included documentation of their inability to ingest solid dosage form?
Is the patient unable to ingest solid dosage form?
Has patient failed a 1-month trial of a generic oral NSAID?
Route for clinical review
PA may be approved

health information designs

Nuedexta Prior Authorization

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 patients receiving a new prescription for Nuedexta must have a diagnosis of amyotrophic lateral sclerosis (ALS) or multiple sclerosis (MS) and exhibit signs of pseudobulbar affect.

Note:

- ***Nuedexta is indicated for the treatment of pseudobulbar affect (PBA).***
- ***Nuedexta has not been shown to be safe or effective in other types of emotional lability that can commonly occur, for example, in Alzheimer's disease and other dementias.***
- ***Nuedexta is contraindicated in patients with a prolonged QT interval, heart failure, or complete atrioventricular (AV) block.***

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ **Nuedexta**	**Diagnosis for this request (must check at least 2):** □ **PBA Include baseline PBA episode count_____** **If request is a renewal, include current PBA episode count_____** □ **ALS** □ **MS**		
List all failed medications:			
Is the Center for Neurological Studies liability baseline attached? (CNS-LS) If request is a renewal, is the CNS-LS current attached? Does the patient have a prolonged QT interval, heart failure, or complete atrioventricular (AV) block? What is the neurologic condition causing PBA? _____ Is TBI due to penetrating head injury? Has the neurologic condition been stable for at least 3 months?			□ YES □ NO □ YES □ NO □ YES □ NO □ YES □ NO □ YES □ NO
Prescriber (or Staff) / Pharmacy Signature		Date	

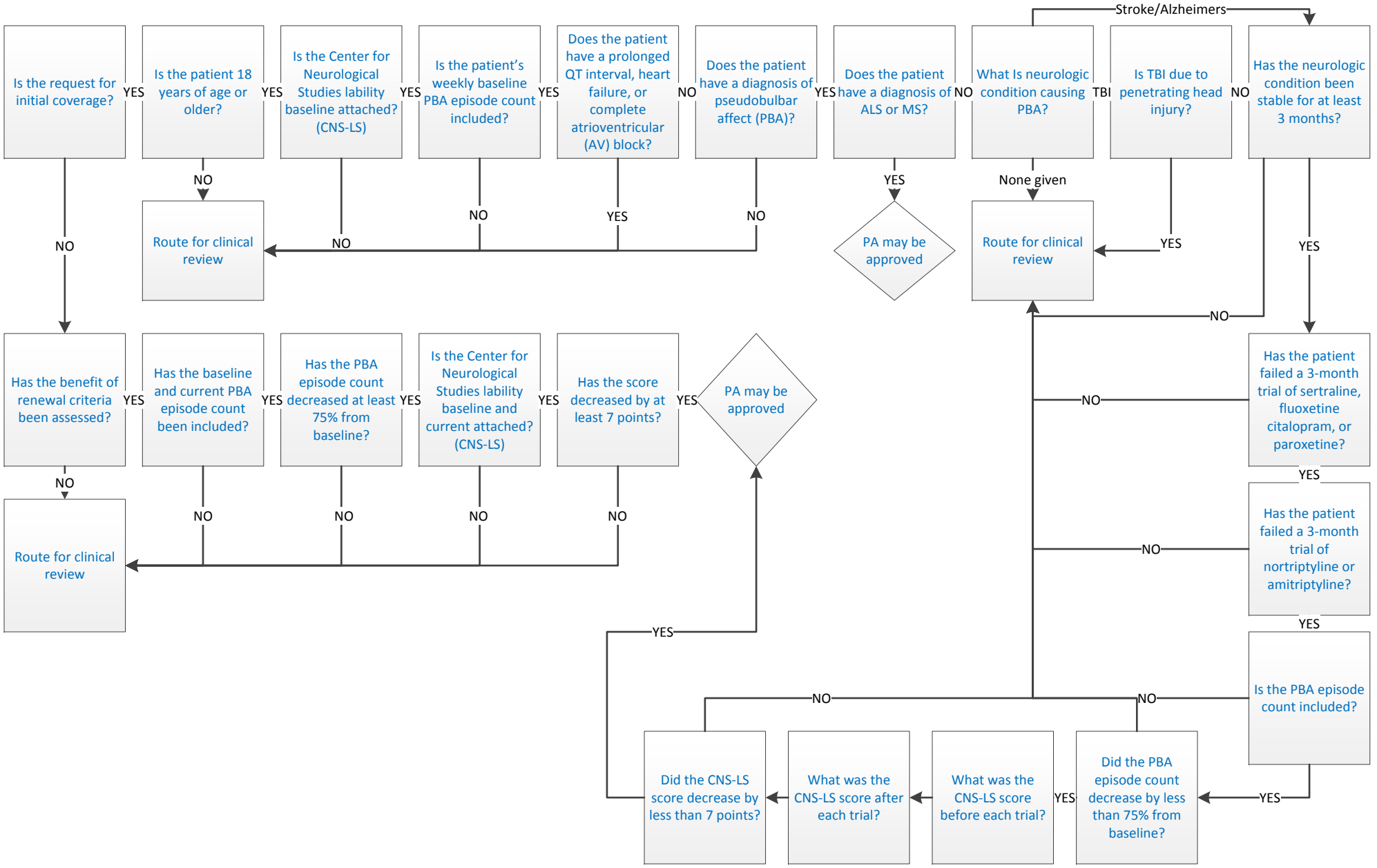
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Nuedexta Authorization Algorithm



health information designs

Prior Authorization Vendor for ND Medicaid

Orally Disintegrating Tablets (ODT) Prior Authorization

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

ND Medicaid requires that patients who are prescribed an orally disintegrating tablet must first try a more cost-effective dosage form.

Part I: TO BE COMPLETED BY PHYSICIAN

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:	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Unable to Swallow □ Medication Failed _____	Start Date: End Date:	Dose: Frequency:	
Physician (or Staff) / Pharmacy Signature		Date	

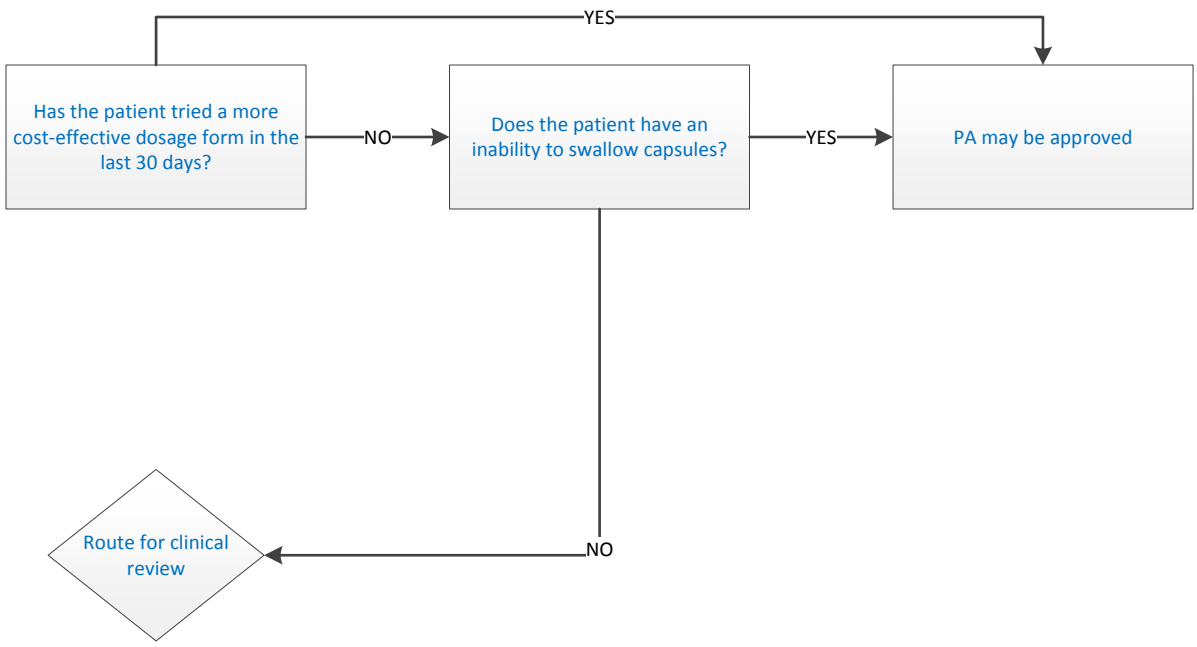
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
ODT Authorization Algorithm



OLYSIO PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Olysio must meet the following criteria:

- Patient must be ≥ 18 years old.
- Must have a diagnosis of chronic hepatitis C, genotype 1, with compensated liver disease.
- Liver biopsy showing fibrosis corresponding to a Metavir score of greater than or equal to 2 or Ishak score of greater than or equal to 3 or other accepted test demonstrating liver fibrosis.
- Must be prescribed by or in consultation with a hepatologist, gastroenterologist, or infectious disease specialist.
- Must be used in combination with pegylated interferon and ribavirin. **(must not be used as monotherapy)**
- Female patients must have a negative pregnancy test within 30 days prior to initiation of therapy and monthly during treatment.
- Documentation showing that patient is drug and alcohol free for the past 12 months
- Alternative therapy should be considered for patients infected with HCV genotype 1a containing the Q80K polymorphism.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name		Recipient Date of Birth	Recipient Medicaid ID Number
Prescriber Name		Specialist involved in therapy	
Prescriber NPI		Telephone Number	Fax Number
Address		City	State / Zip Code
Requested Drug □ **Olysio** Dosage _____	**Documented liver fibrosis** **Presence of Q80K polymorphism?** □ YES □ NO	**Diagnosis for this request** **Genotype** **Pegylated interferon dose** **Ribavirin dose**	**Patient is drug and alcohol free for past 12 months** □ YES □ NO **Negative pregnancy test in the past 30 days** □ YES □ NO
Has the patient been previously treated for chronic hepatitis C? □ YES □ NO If yes, please indicate past treatment regimen(s), dates of treatment, and response to therapy:			Baseline HCV RNA: HCV RNA 4 weeks after starting therapy:
Prescriber (or Staff) / Pharmacy Signature			Date

Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received:	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

Hepatitis C Patient Consent Form

I, _____, have been counseled by my healthcare provider on the following:

- ☐ I agree to complete the entire course of treatment and have laboratory tests before starting, during, and after completing treatment as ordered by my healthcare provider.
- ☐ I understand that for the medication to work, it is important that I take my medication each day for the entire course of treatment.
- ☐ I understand the importance to not drink alcohol or use illicit drugs during and after my treatment for Hepatitis C.
- ☐ I understand how to avoid being re-infected with Hepatitis C during and after my treatment.
- ☐ (Females) I understand that these drugs are harmful to babies. I will use two methods to avoid getting pregnant. I understand that this medication may cause serious birth defects to an unborn child for up to 6 months after I have completed my treatment.
- ☐ (Males) I understand that while I am taking the medication, I must avoid getting my partner pregnant. If my partner becomes pregnant, the baby may have serious birth defects. My partner and I will prevent pregnancy using two forms of birth control for up to 6 months after my treatment is complete. If I have a committed partner, I have discussed these risks with her.

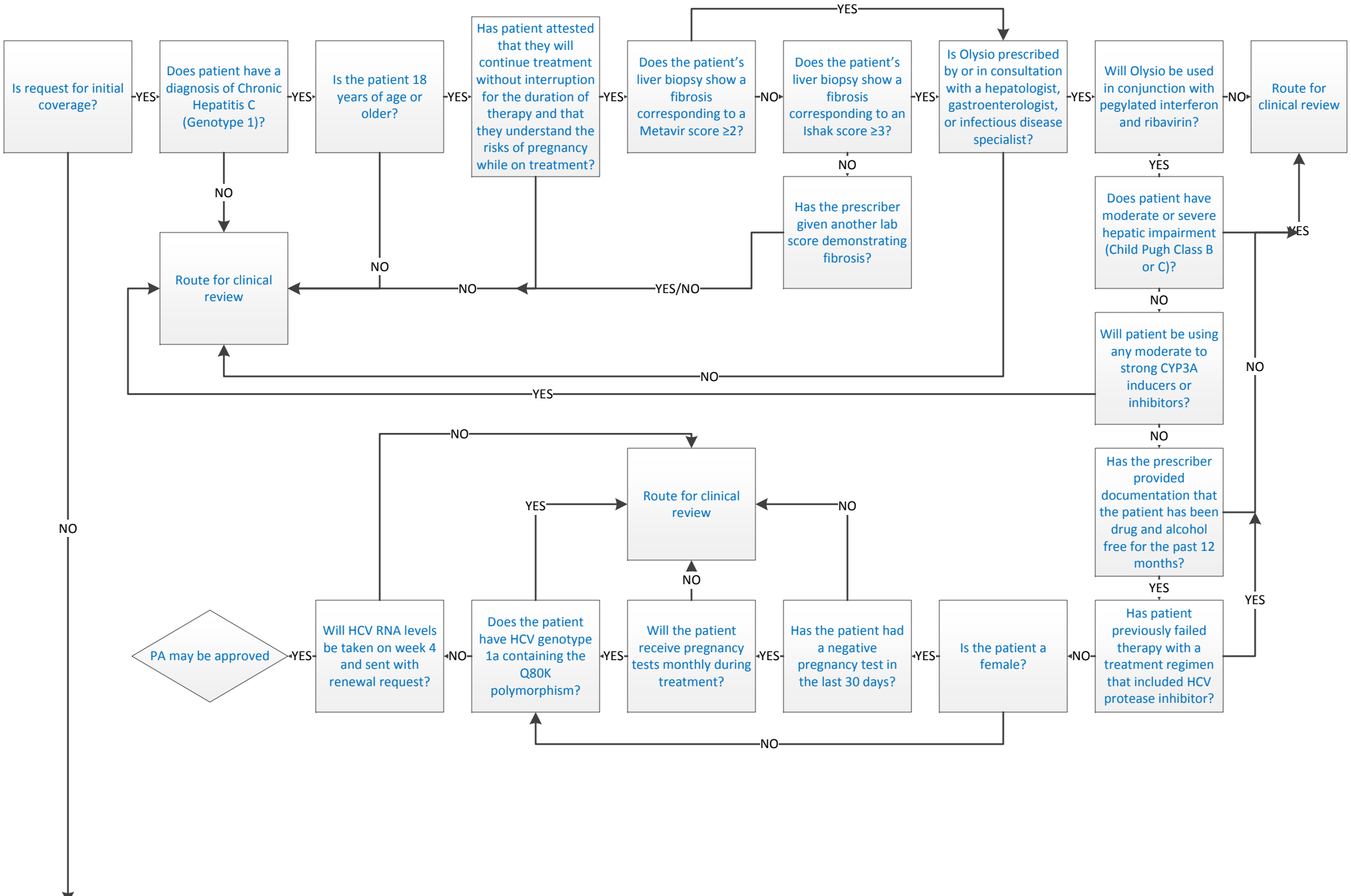
Patient Signature _____ Date __/__/____

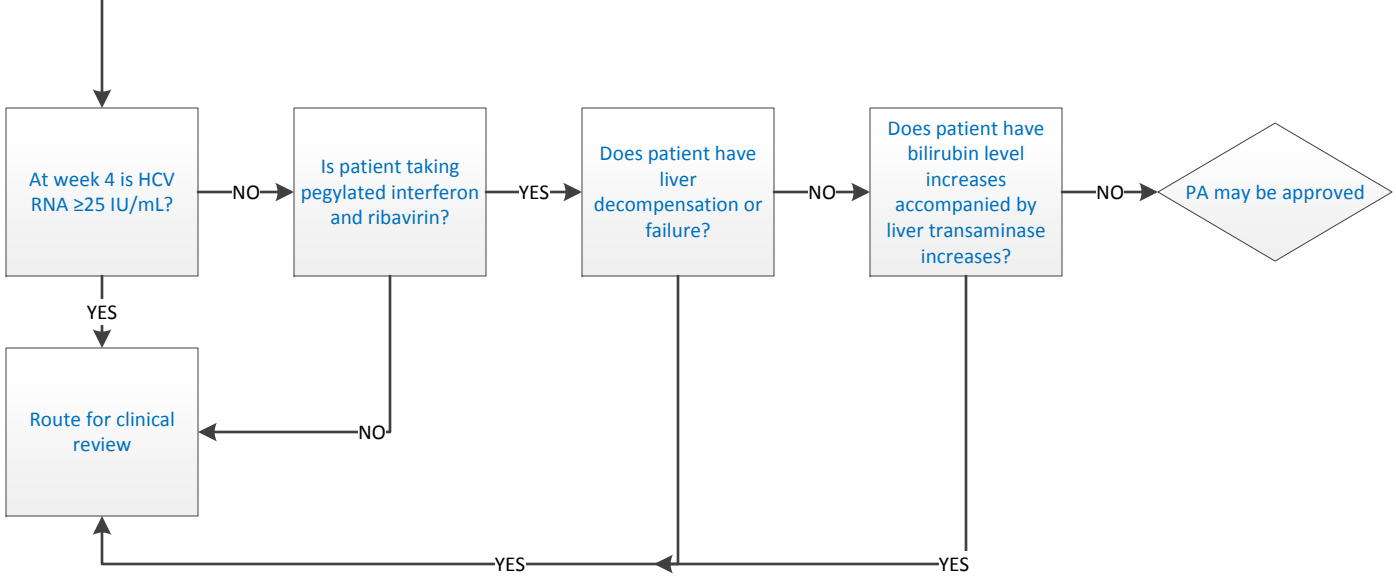
Pharmacy or Prescriber Representative:

Signature _____ Date __/__/____

By signature, the pharmacy or prescriber representative confirms the contract has been reviewed with the patient.

North Dakota Department of Human Services
Olysio Authorization Algorithm




At week 4 is HCV RNA ≥25 IU/mL?
NO
Is patient taking pegylated interferon and ribavirin?
YES
Does patient have liver decompensation or failure?
NO
Does patient have bilirubin level increases accompanied by liver transaminase increases?
NO
PA may be approved
YES
Route for clinical review
NO
YES
YES

health information designs

Onmel
Prior Authorization

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 patients receiving a new prescription for Onmel must meet the following criteria:

- *Patient must receive two medically necessary courses of therapy with itraconazole (Sporanox) and terbinafine (Lamisil)*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

QUALIFICATIONS FOR COVERAGE:

Requested Drug and Dosage: □ **Onmel**	Diagnosis for this request:
Prescriber (or Staff) / Pharmacy Signature	Date

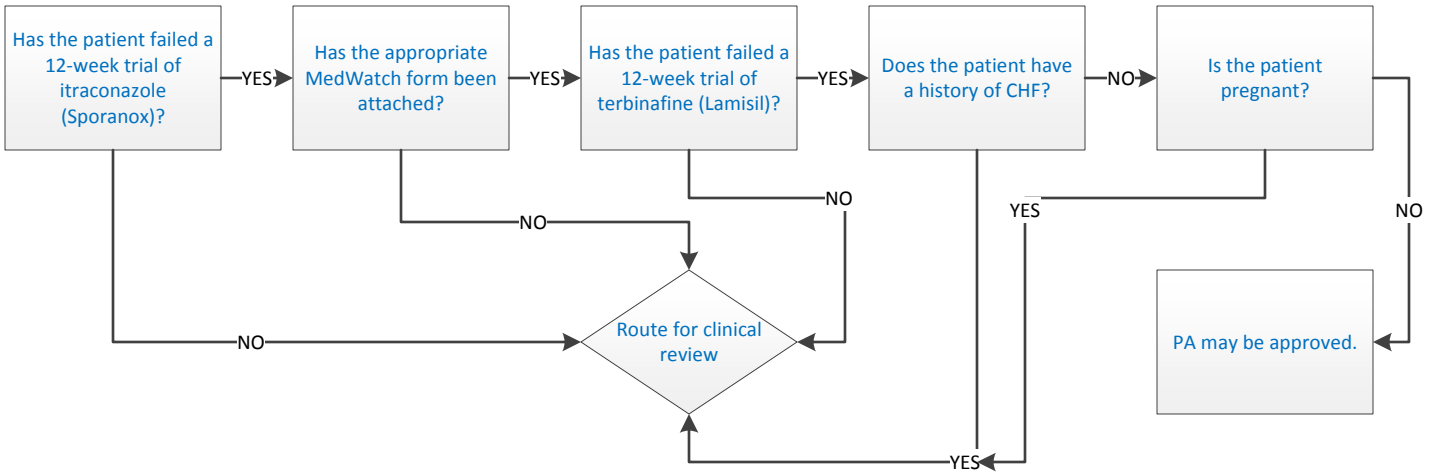
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Onmel Authorization Algorithm



ONYCHOMYCOSIS AGENTS
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 onychomycosis treatment must meet the following criteria:

- **Patient must have a confirmed diagnosis of onychomycosis by one of the following: KOH prep test, fungal culture, or nail biopsy.**
- **Patient must have a history of failure to itraconazole and/or terbinafine.**

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ JUBLIA □ KERYDIN □ SPORANOX (ITRACONAZOLE) □ ONMEL (ITRACONAZOLE)	Diagnosis: Confirmed diagnosis by (provide documentation): □ KOH PREP TEST □ FUNGAL CULTURE □ NAIL BIOPSY Is treatment for fingernails only? □ YES □ NO	<u>First Trial:</u> Start Date: End Date: <u>Second Trial:</u> Start Date: End Date:	
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature		Date	

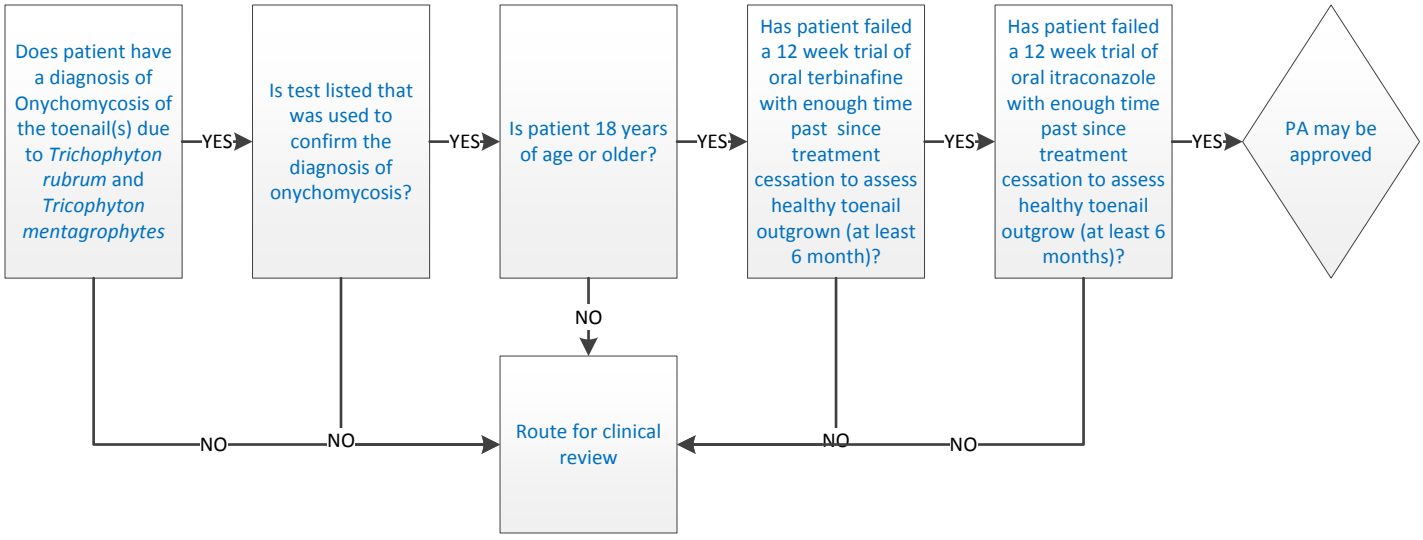
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Onychomycosis Agents Authorization Algorithm



OPHTHALMIC ANTI-INFECTIVE PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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

ND Medicaid will not pay for Azasite, Quixin, or Moxeza without documented failure of a first line antibiotic ophthalmic agent.

***Note: First line agents include sulfacetamide (Bleph 10®, etc.), erythromycin, bacitracin-polymixin B (Polysporin®), polymyxin B neomycin-gramicidin (Neosporin®), trimethoprim-polymyxin B (Polytrim®), gentamicin (Garamycin®, etc.), ofloxacin (Ocuflox®) and ciprofloxacin (Ciloxan®).**

- **Requires step therapy. See Ophthalmic Anti-Infective Criteria**

Part I: TO BE COMPLETED BY PRESCRIBER

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: □ AZASITE □ MOXEZA □ QUIXIN	**Diagnosis for this request:**		
List all failed medications:			
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature	Date		

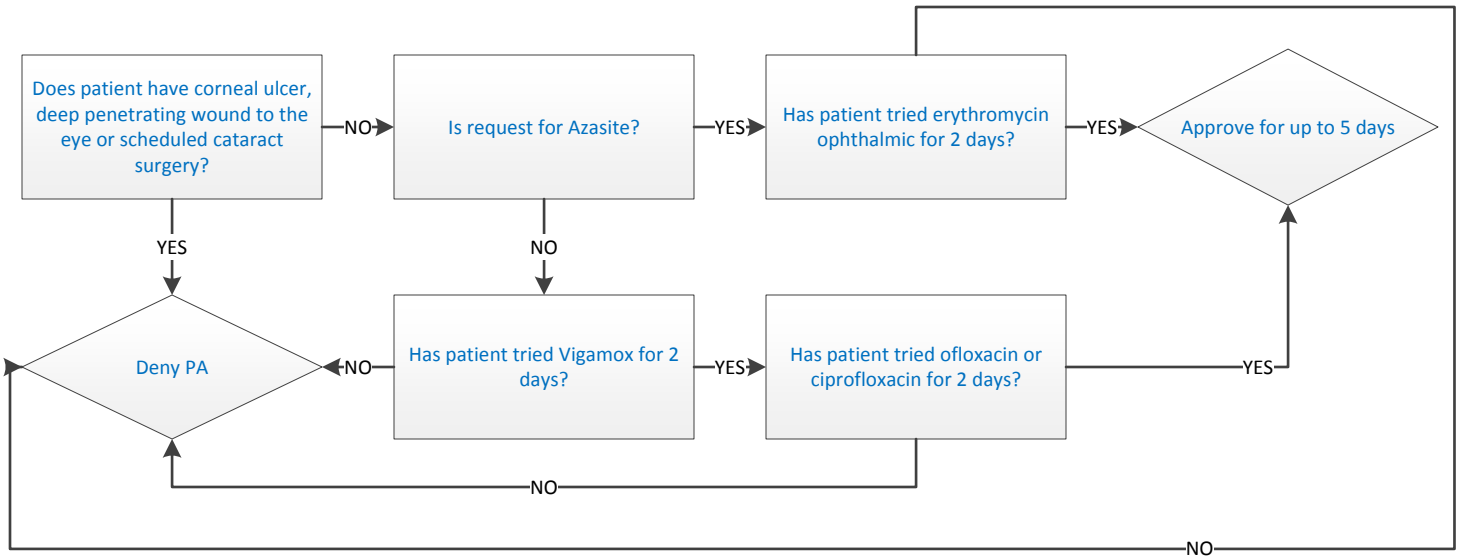
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Ophthalmic Anti-infectives Authorization Algorithm



health information designs

Prior Authorization Vendor for ND Medicaid

Ophthalmic Antihistamines Prior Authorization

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 Lastacaft, Bepreve, and Pataday must first try one of the following:

- ***Azelastine, Emadine, and Patanol do not require a prior authorization.***

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ **Lastacaft** □ **Bepreve** □ **Pataday** □ **Elastat**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED THERAPY START DATE: DOSE: END DATE: FREQUENCY:			
Prescriber (or Staff) / Pharmacy Signature		Date	

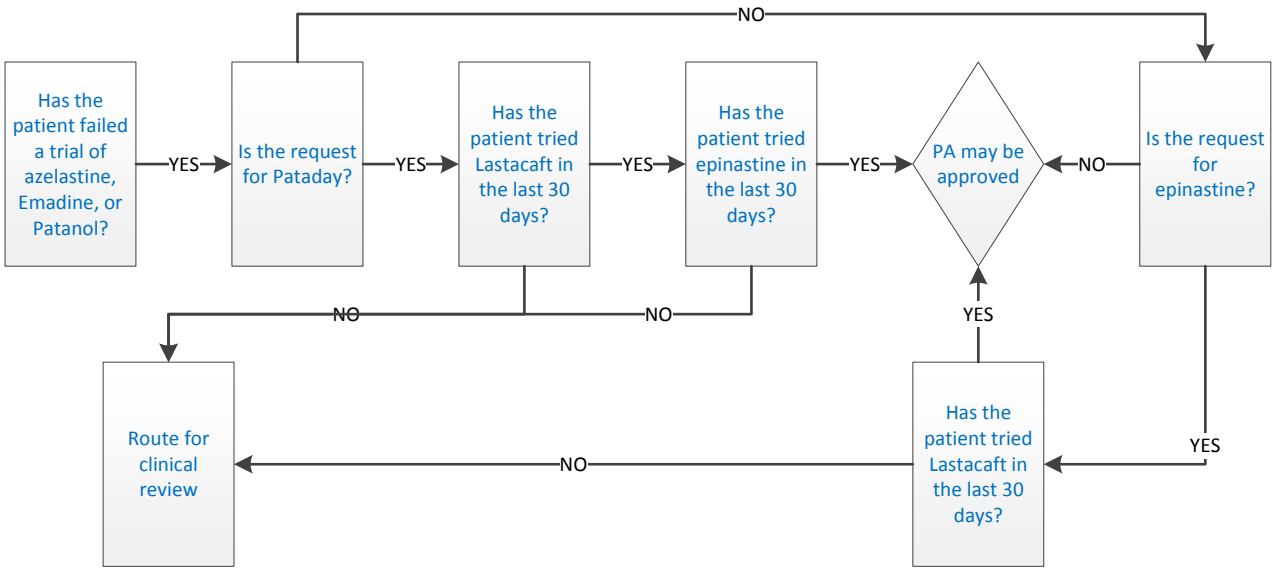
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Ophthalmic Antihistamines Authorization Algorithm



health information designs

ROSACEA/ACNE PA FORM

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

Prior Authorization Vendor for ND Medicaid

Note: ND Medicaid will not pay for Solodyn, Soolantra, Doryx, Adoxa, or Oracea without documented failure of a first line tetracycline agent.

- First line agents include minocycline and tetracycline.
- Requires step therapy. See Oracea criteria for more information.

Part I: TO BE COMPLETED BY PRESCRIBER

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	
PRESCRIBER NAME:	PRESCRIBER NPI:
Address:	Phone: ( )
City:	FAX: ( )
State: Zip:	

REQUESTED DRUG: □ **ORACEA** □ **DORYX** □ **SOLODYN** □ **SOOLANTRA** □ **ADOXA**	**Requested Dosage:** (must be completed)

Qualifications for coverage:

□ Patient has failed a 90 day trial of which first line agent _____
□ Moderate to severe acne
□ Severe acne

List all failed medications:

□ *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 recipient.*

Prescriber (or Staff) / Pharmacy Signature: Date:

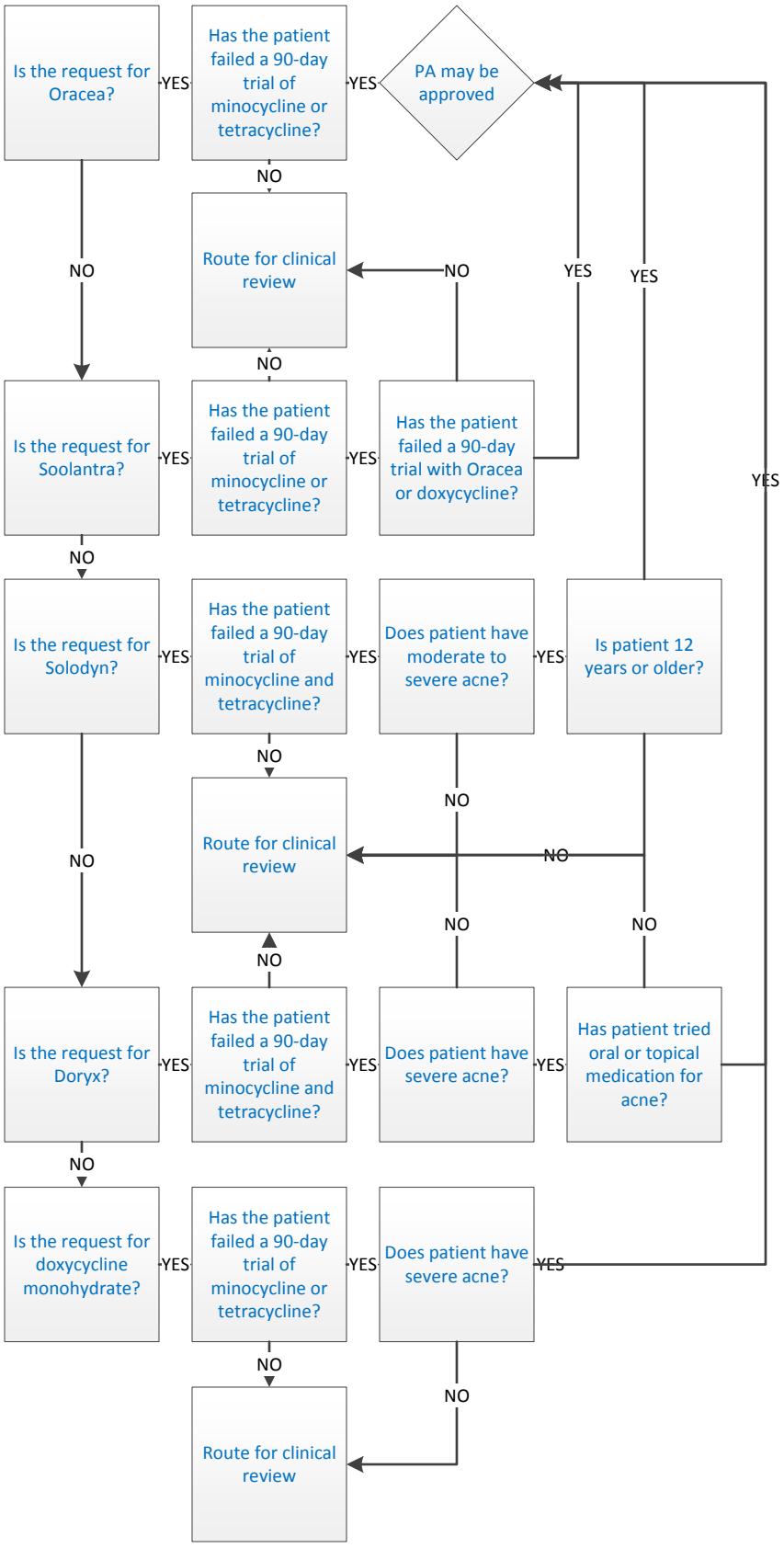
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAIDPROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Part III: FOR OFFICIAL USE ONLY

Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	

North Dakota Department of Human Services
Rosacea/Acne Authorization Algorithm



ORAL ALLERGEN EXTRACTS
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 oral allergen extracts must meet the following criteria:

- **Patient must have the FDA approved indication for the drug requested.**
- **Diagnosis confirmed by positive skin test or *in vitro* testing for pollen-specific IgE antibodies.**
- **History of failure, contraindication, or intolerance to two of the following: oral antihistamine, intranasal antihistamine, intranasal corticosteroid, or leukotriene inhibitors.**
- **History of failure or intolerance to subcutaneous allergen immunotherapy (allergy shots).**
- **Patient must not have severe, unstable, or uncontrolled asthma.**

Part I: TO BE COMPLETED BY PHYSICIAN

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:	**Diagnosis for this Request:**	**History of Failure:**
□ GRASTEK	□ GRASS POLLEN-INDUCED ALLERGIC RHINITIS	**1.**
□ ORALAIR	□ RAGWEED POLLEN-INDUCED ALLERGIC RHINITIS	**2.**
□ RAGWITEK	Is the diagnosis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies? □ YES □ NO Doe the patient have severe, unstable, or uncontrolled asthma? □ YES □ NO	**3.**

□ *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 recipient.*

Prescriber (or Staff) / Pharmacy Signature	Date

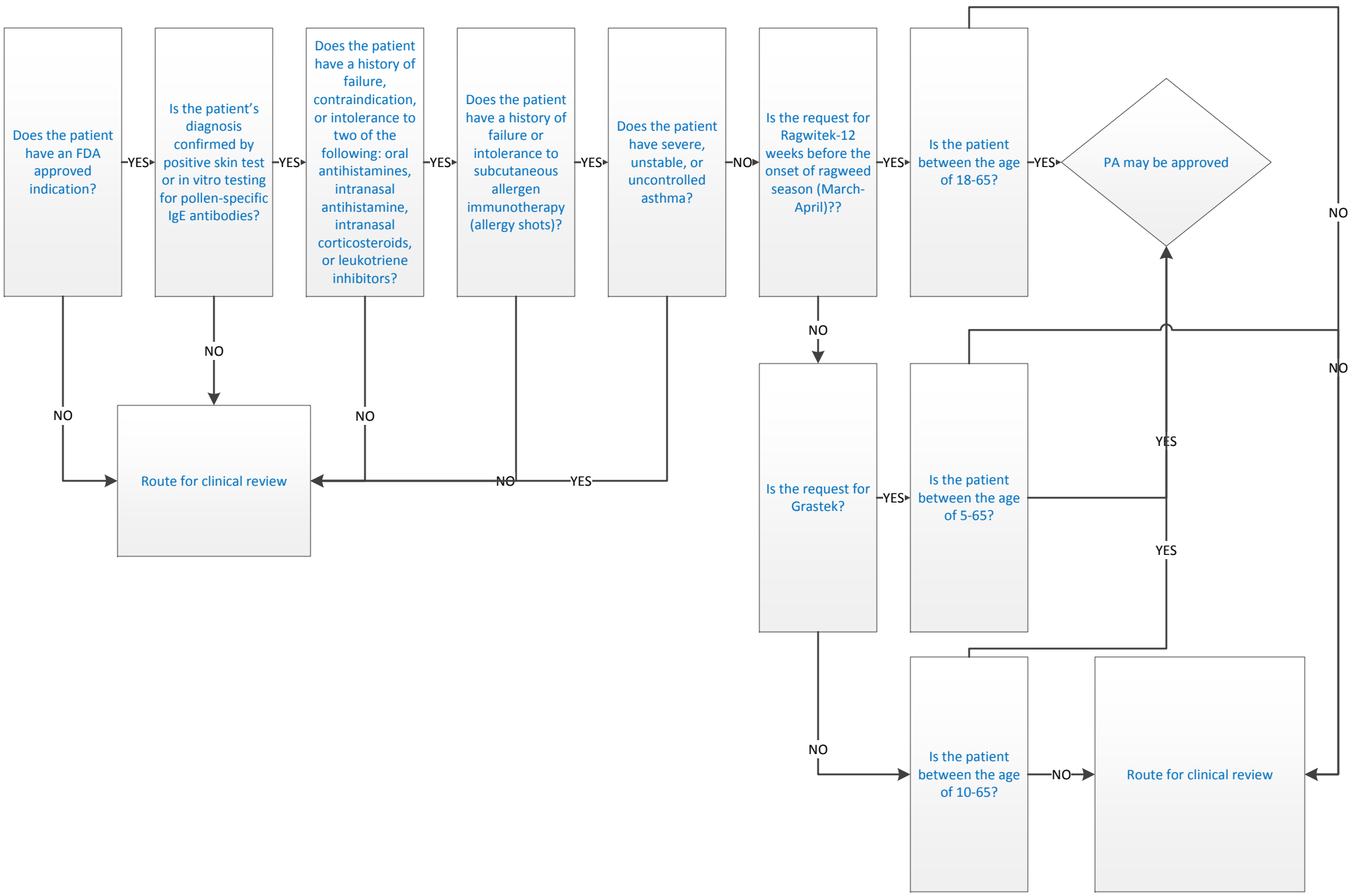
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Oral Allergens Authorization Algorithm



ORAL ANTICOAGULANTS
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Pradaxa, Xarelto, Eliquis, or Savaysa must meet the following criteria:

- **Patient must have an FDA approved indication.**

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ PRADAXA □ XARELTO □ ELIQUIS □ SAVAYSA	**Diagnosis for this Request:**		
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature		Date	

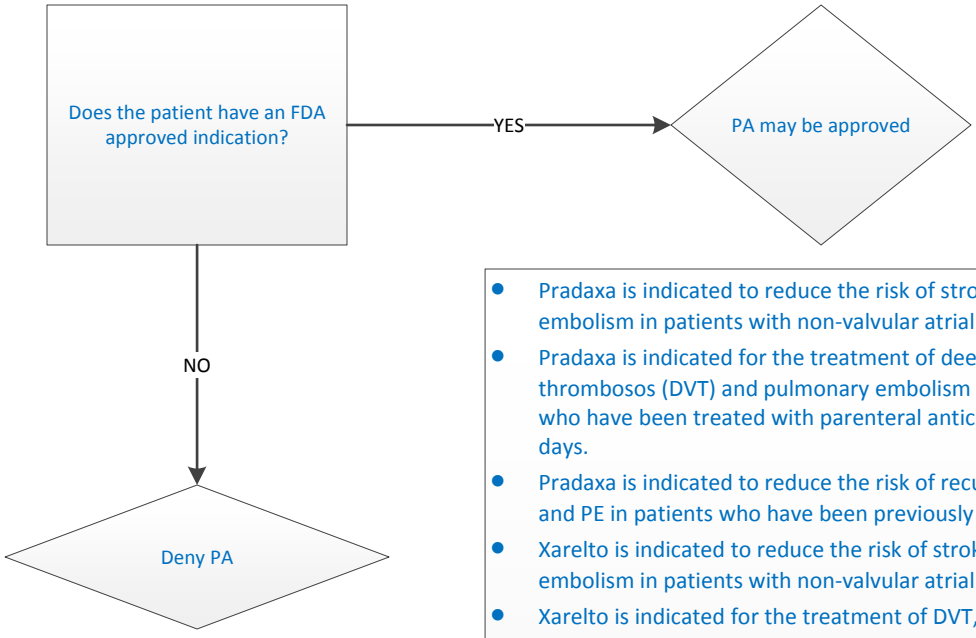
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Oral Anticoagulants Authorization Algorithm



- Pradaxa is indicated to reduce the risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation.
- Pradaxa is indicated for the treatment of deep vein thrombosos (DVT) and pulmonary embolism (PE) in patients who have been treated with parenteral anticoagulant for 5-10 days.
- Pradaxa is indicated to reduce the risk of recurrence of DVT and PE in patients who have been previously treated.
- Xarelto is indicated to reduce the risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation.
- Xarelto is indicated for the treatment of DVT, PE, and for the reduction in the risk of recurrence of DVT and of PE.
- Xarelto is indicated for the prophylaxis of DVT, which may lead to PE in patients undergoing knee or hip replacement surgery.
- Eliquis is indicated to reduce the risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation.
- Eliquis is indicated for the prophylaxis of DVT, which may lead to PE, in patients who have undergone hip or knee replacement surgery.
- Eliquis is indicated for the treatment of DVT and PE, and for the reduction in the risk of recurrent DVT and PE following initial therapy.
- Savaysa is indicated to reduce the risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation.
- Savaysa is indicated for the treatment of DVT and PE following 5-10 days of initial therapy with a parenteral anticoagulant.

Oravig Prior Authorization

health information designs

Prior Authorization Vendor for ND Medicaid

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

ND Medicaid requires patients receiving a prescription for Oravig to try fluconazole, clotrimazole, nystatin or itraconazole.
Note:

- ***Fluconazole, clotrimazole, nystatin, or itraconazole do not require PA***

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ **Oravig**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ **Medication failed** _____	**Start Date:** **End Date:**	**Dose:** **Frequency:**	
Prescriber (or Staff) / Pharmacy Signature		Date	

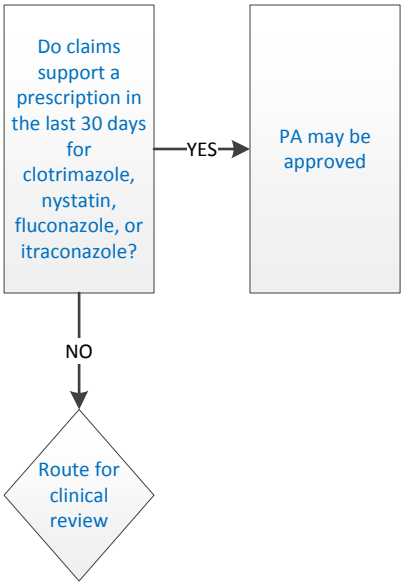
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Oravig Authorization Algorithm



OTEZLA
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Otezla must meet the following criteria:

- **Patient must be 18 years of age or older.**
- **Patient must have active psoriatic arthritis or moderate to severe plaque psoriasis.**
- **Patient must have a specialist involved in therapy.**
- **Patient must not use Otezla in combination with other biologic therapies.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name		Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name		Specialist Involved in Therapy		
Prescriber NPI		Telephone Number	Fax Number	
Address		City	State	Zip Code
Requested Drug: □ OTEZLA	Diagnosis for this Request:	History of Failure:	Is Otezla being used in combination with other biologic therapies?	
□ *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 recipient.*				
Prescriber (or Staff)/Pharmacy Signature			Date	

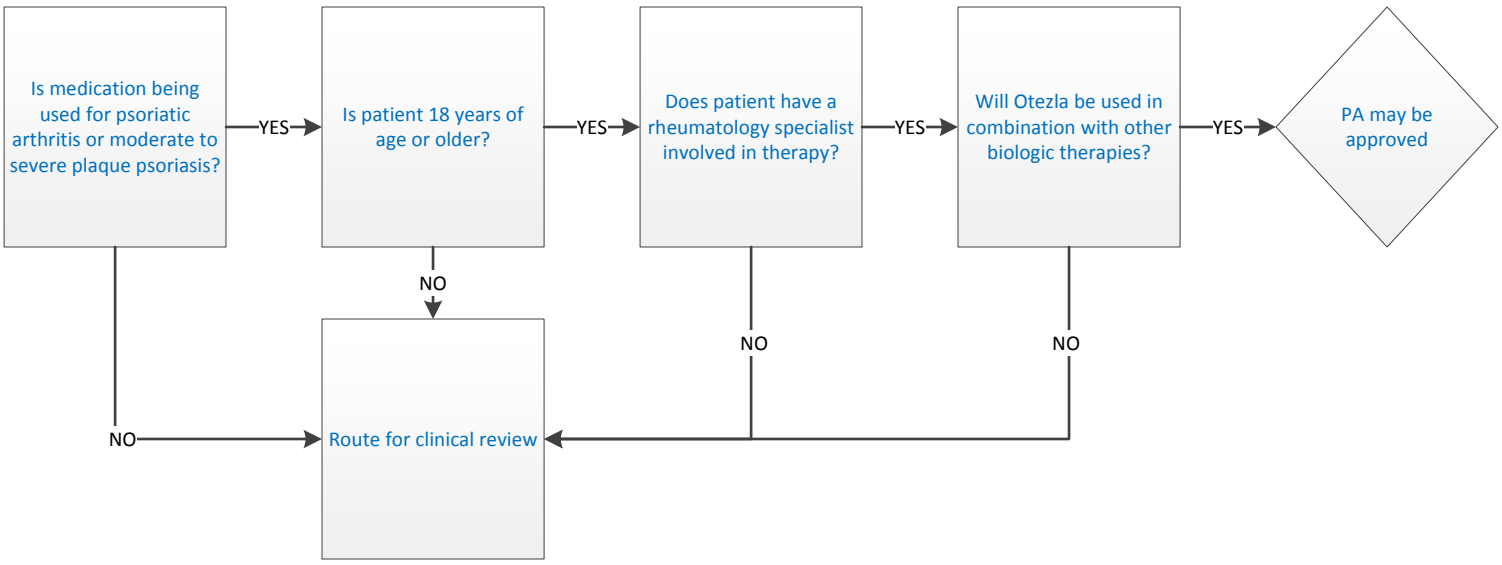
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Otezla Authorization Algorithm



OUT OF STATE PHARMACY FORM

health information designs

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

Prior Authorization Vendor for ND Medicaid

Part I

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number

Requested Drug and Dosage:

Qualifications for coverage:

Start Date	End Date	Dose	Frequency

Reason for out of state pharmacy request:

Recipient is residing out of state? □ YES □ NO
If yes, please provide recipient residence, city, state, zip code:

Requested drug is only available at out of state pharmacies? □ YES □ NO

Third party requires out of state pharmacy for coverage? □ YES □ NO
If yes, contact State Provider Relations at 1-800-755-2604.

Part II

PHARMACY NAME (REQUIRED)			ND MEDICAID PROVIDER NUMBER (REQUIRED)
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC # (REQUIRED)

Pharmacy Signature:	Date:

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

PULMONARY ARTERIAL HYPERTENSION AGENTS
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 an agent used to treat pulmonary arterial hypertension (PAH) must meet the following criteria:

- **Patient must have diagnosis of PAH confirmed by a specialist**
- **Requires step therapy. Please see PAH criteria for more information.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name	Specialist Involved in therapy:		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:

□ LETAIRIS □ TRACLEER □ VENTAVIS

□ REVATIO □ ADCIRCA □ TYVASO

□ OPSUMIT □ ORENITRAM

□ OTHER_____

Diagnosis for this Request:

Is the patient pregnant?	□ Yes □ No
Will patient take monthly pregnancy tests during therapy?	□ Yes □ No
Have LFT's been measured for baseline?	□ Yes □ No
Will LFT's be measured monthly?	□ Yes □ No
Does the patient have Class 2 PAH?	□ Yes □ No
Is the patient taking nitrates of any form?	□ Yes □ No
If the request is for Tyvaso, is the patient also taking sildenafil, Adcirca, Letairis, bosentan, or Opsumit?	□ Yes □ No
If the request is for Ventavis 20mcg/mL is the patient repeatedly experiencing incomplete dosing due to extended treatment time?	□ Yes □ No

PLEASE LIST ALL FAILED MEDICATIONS:

□ *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 recipient.*

Prescriber (or Staff) / Pharmacy Signature	Date

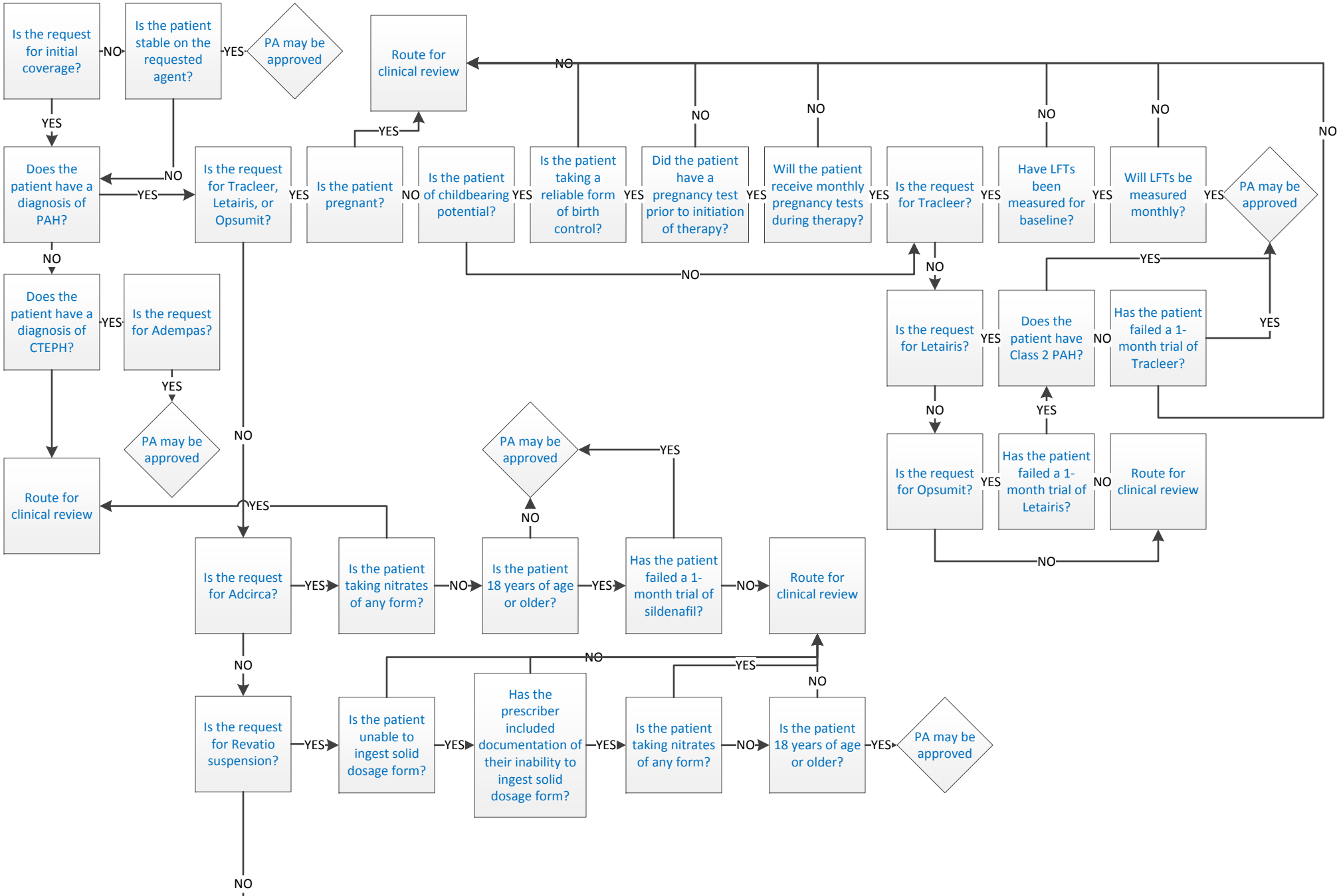
Part II: TO BE COMPLETED BY PHARMACY

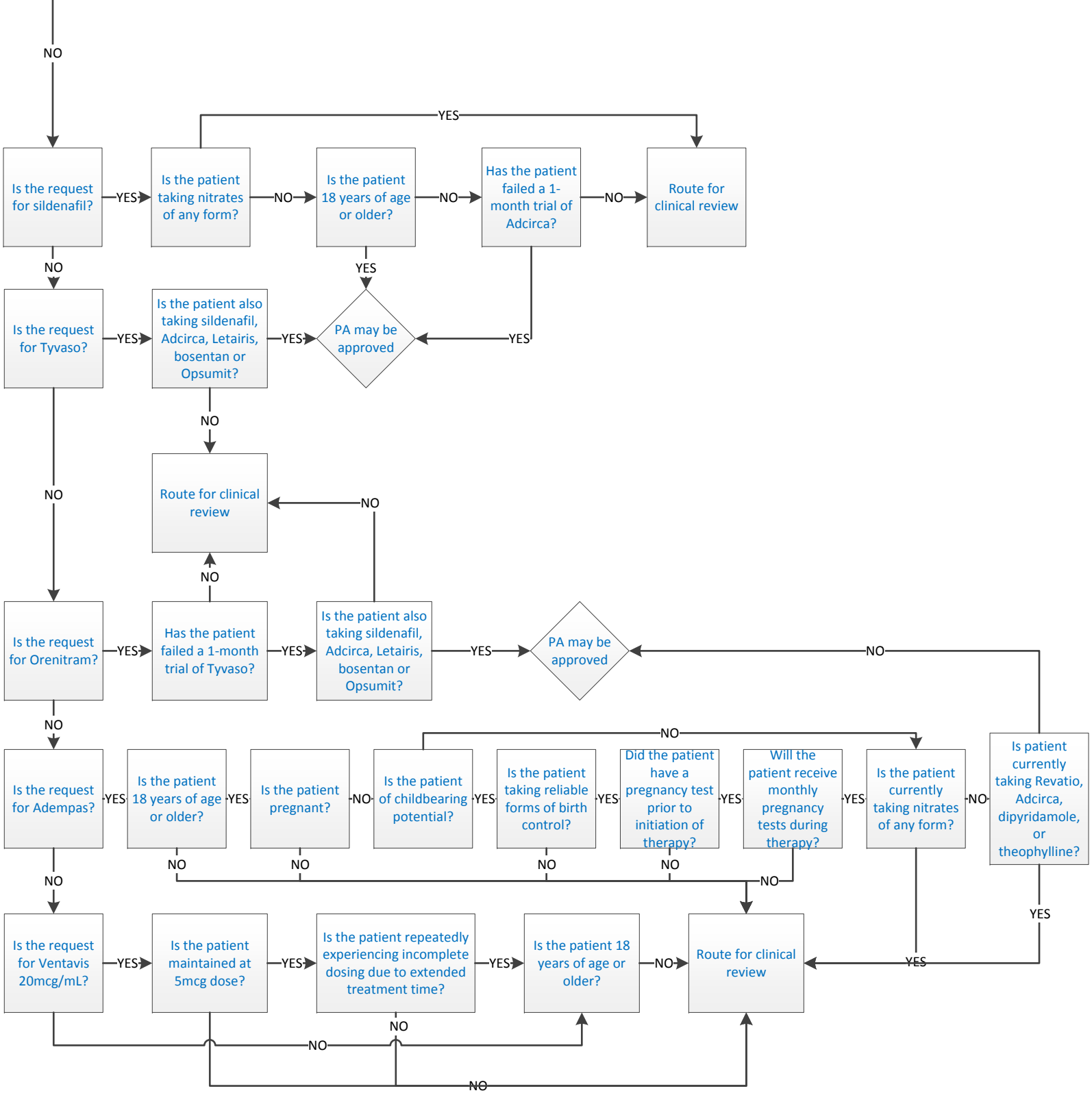
PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Pulmonary Arterial Hypertension Agents Authorization Algorithm




NO
Is the request for sildenafil?
YES
Is the patient taking nitrates of any form?
YES
NO
Is the patient 18 years of age or older?
NO
Has the patient failed a 1-month trial of Adcirca?
NO
Route for clinical review
NO
YES
Is the request for Tyvaso?
YES
Is the patient also taking sildenafil, Adcirca, Letairis, bosentan or Opsumit?
YES
PA may be approved
YES
NO
Route for clinical review
NO
NO
Is the request for Orenitram?
YES
Has the patient failed a 1-month trial of Tyvaso?
NO
YES
Is the patient also taking sildenafil, Adcirca, Letairis, bosentan or Opsumit?
YES
PA may be approved
NO
NO
Is the request for Adempas?
YES
Is the patient 18 years of age or older?
YES
Is the patient pregnant?
NO
Is the patient of childbearing potential?
YES
Is the patient taking reliable forms of birth control?
YES
Did the patient have a pregnancy test prior to initiation of therapy?
YES
Will the patient receive monthly pregnancy tests during therapy?
YES
Is the patient currently taking nitrates of any form?
NO
Is patient currently taking Revatio, Adcirca, dipyridamole, or theophylline?
NO
NO
NO
NO
NO
NO
NO
YES
YES
NO
Is the request for Ventavis 20mcg/mL?
YES
Is the patient maintained at 5mcg dose?
YES
Is the patient repeatedly experiencing incomplete dosing due to extended treatment time?
YES
Is the patient 18 years of age or older?
NO
Route for clinical review
YES
NO
NO
NO

health information designs

Prior Authorization Vendor for ND Medicaid

PHOSPHATE BINDERS
PA 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 phosphate binders must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Requires step therapy. See phosphate binder criteria for more information.**

Part I: TO BE COMPLETED BY PHYSICIAN

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:	Diagnosis:	Does patient have any soft tissue or vascular calcification? □YES □NO Does patient have chronic kidney disease? □YES □NO If so, what stage? _____
□ RENAGEL _____ □ FOSRENOL_____ □ RENVELA _____ □ VELPHORO _____ □ AURYXIA _____	Lab: Corrected Calcium Level:_____ Phosphate Level:_____ Ca x Ph _____ iPTH Level:_____	List failed medications and tell reason:

□ *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 recipient.*

Prescriber (or Staff) / Pharmacy Signature	Date

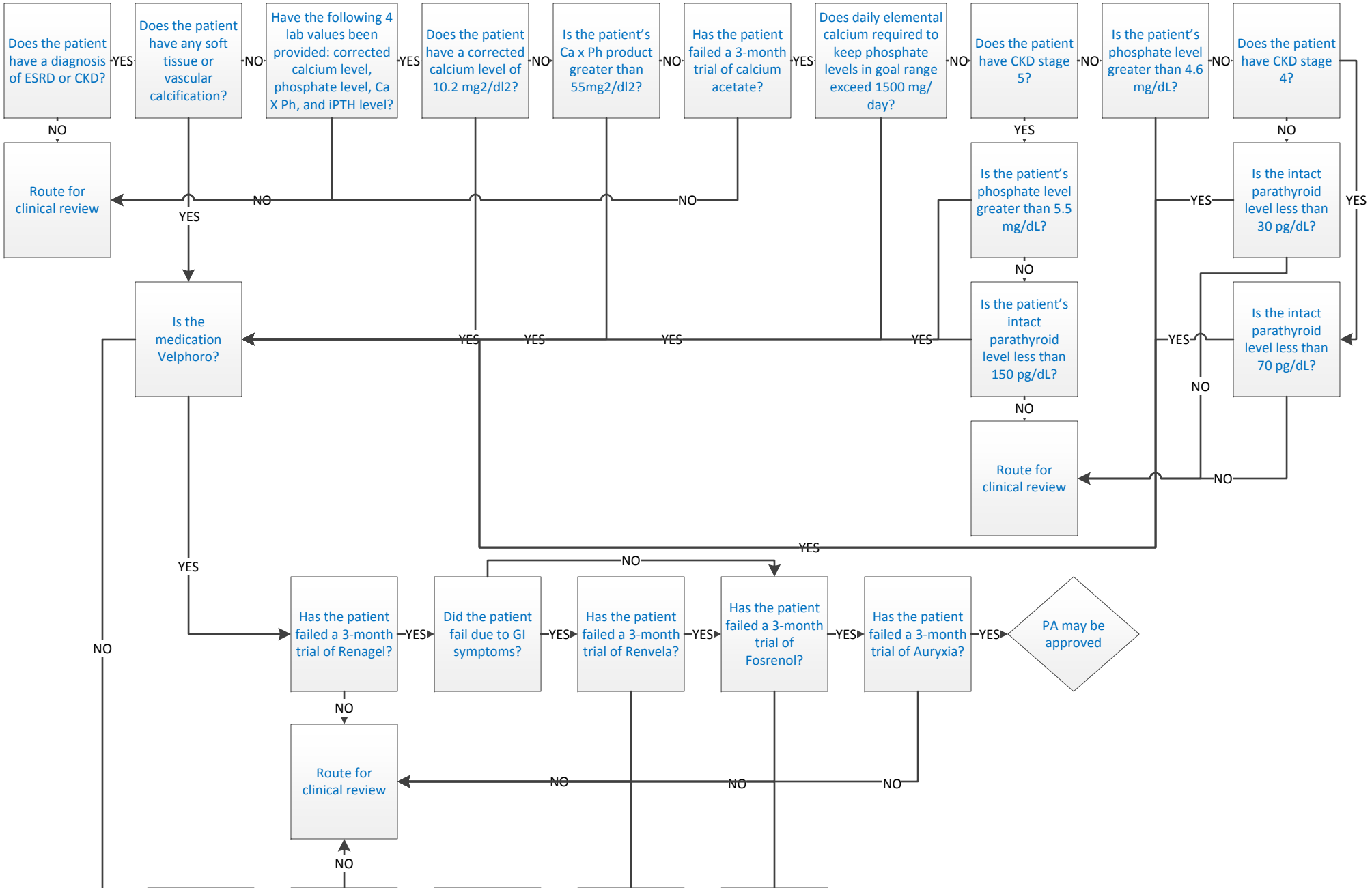
Part II: TO BE COMPLETED BY PHARMACY

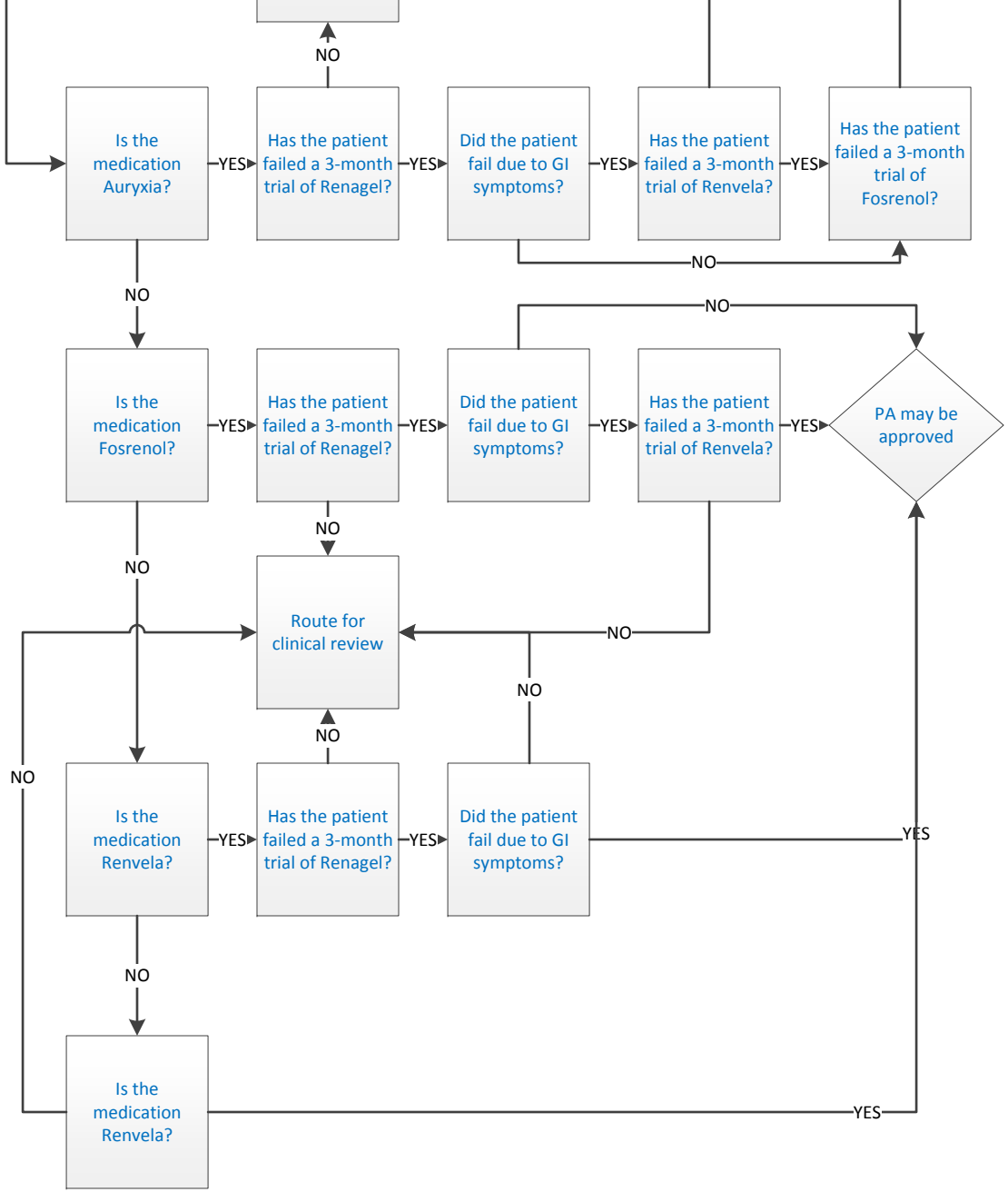
PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Phosphate Binders Authorization Algorithm




NO
Is the medication Auryxia?
YES
Has the patient failed a 3-month trial of Renagel?
YES
Did the patient fail due to GI symptoms?
YES
Has the patient failed a 3-month trial of Renvela?
YES
Has the patient failed a 3-month trial of Fosrenol?
NO
NO
Is the medication Fosrenol?
YES
Has the patient failed a 3-month trial of Renagel?
YES
Did the patient fail due to GI symptoms?
YES
Has the patient failed a 3-month trial of Renvela?
YES
PA may be approved
NO
NO
NO
Route for clinical review
NO
NO
NO
Is the medication Renvela?
YES
Has the patient failed a 3-month trial of Renagel?
YES
Did the patient fail due to GI symptoms?
YES
NO
Is the medication Renvela?
YES

health information designs

Proton Pump Inhibitor PA 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 patients receiving proton pump inhibitors must use omeprazole or pantoprazole as first line.

Note:

- **Omeprazole and Pantoprazole may be prescribed WITHOUT prior authorization.**
- **Patients must use omeprazole or pantoprazole for a minimum of 14 days for the trial to be considered a failure. Patient preference does not constitute a failure.**
- **Requires step therapy. See PPI criteria for more information.**

Part I: TO BE COMPLETED BY PRESCRIBER

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	
PRESCRIBER NAME:	PRESCRIBER NPI:
Address:	Phone: ( )
City:	FAX: ( )
State: Zip:	

REQUESTED DRUG: □ Rabeprazole □ Lansoprazole □ Prevacid Solutab □ Zegerid Packet □ Protonix Packet □ Nexium □ Dexilant □ Aciphex Sprinkle	**Requested Dosage:** (must be completed) **Diagnosis for this request:**

Qualifications for coverage:

Failed therapy (list all)	Start Date:	Dose:
	End Date:	Frequency:
□ Pregnancy – Due Date		
□ Inability to take or tolerate oral tablets (must check a box) □ Tube Fed □ Requires soft food or liquid administration □ Other (provide description)		
□ Adverse reaction (attach FDA Medwatch form) to omeprazole/lansoprazole.		
□ *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 recipient.*		
Prescriber (or Staff) / Pharmacy Signature:		Date:

Part II: TO BE COMPLETED BY PHARMACY

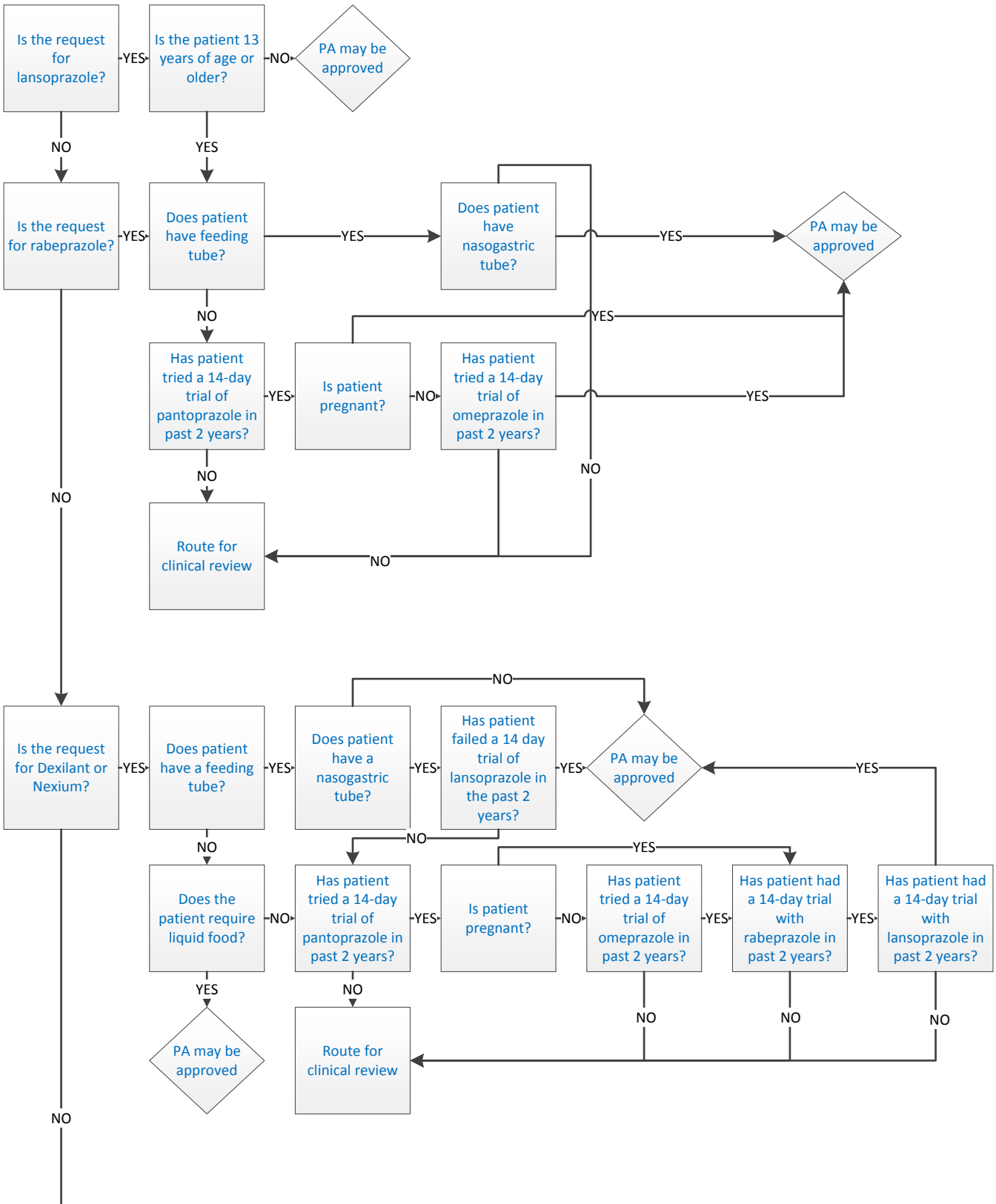
PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

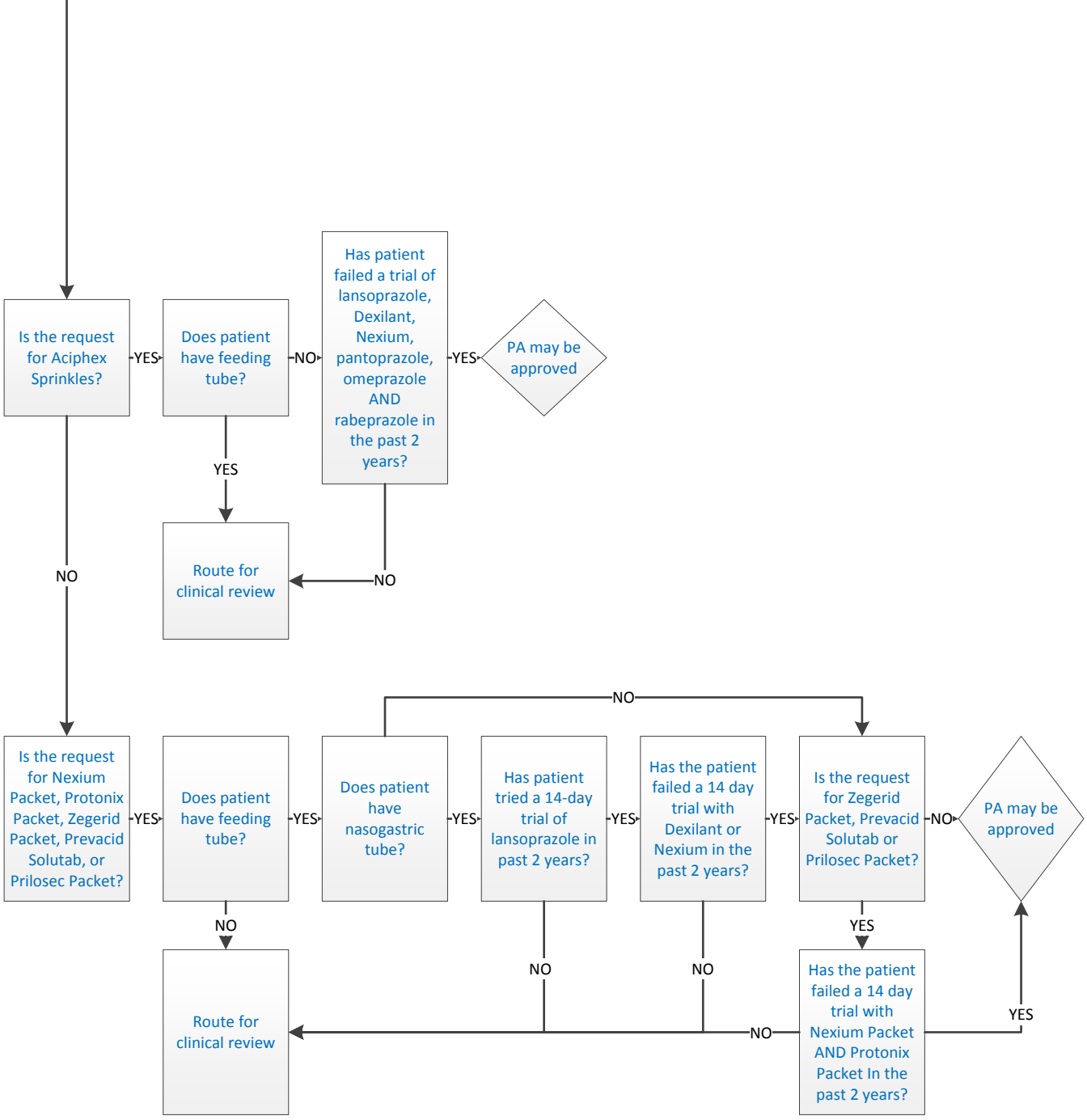
Part III: FOR OFFICIAL USE ONLY

Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	

Revised: 06/04/2015

North Dakota Department of Human Services
PPI Authorization Algorithm




Is the request for Aciphex Sprinkles?
YES
Does patient have feeding tube?
NO
Has patient failed a trial of lansoprazole, Dexilant, Nexium, pantoprazole, omeprazole AND rabeprazole in the past 2 years?
YES
PA may be approved
YES
NO
Route for clinical review
NO
Is the request for Nexium Packet, Protonix Packet, Zegerid Packet, Prevacid Solutab, or Prilosec Packet?
YES
Does patient have feeding tube?
YES
Does patient have nasogastric tube?
YES
Has patient tried a 14-day trial of lansoprazole in past 2 years?
YES
Has the patient failed a 14 day trial with Dexilant or Nexium in the past 2 years?
YES
Is the request for Zegerid Packet, Prevacid Solutab or Prilosec Packet?
NO
PA may be approved
NO
NO
YES
NO
NO
Route for clinical review
NO
Has the patient failed a 14 day trial with Nexium Packet AND Protonix Packet In the past 2 years?
YES

Promacta Prior Authorization

health information designs

Prior Authorization Vendor for ND Medicaid

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

ND Medicaid requires that patients who are prescribed Promacta must follow these guidelines:

- ***Patient must have a confirmed diagnosis of chronic immune (idiopathic) thrombocytopenia, Severe Aplastic Anemia, or Hepatitis C.***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Qualifications for coverage:			
Requested Drug and Dosage: □ **Promacta**	**Diagnosis for this request:**		
□ **Failed corticosteroid or immunoglobulin therapy** **DRUG:** **Start Date:** **End Date:** **Dose:** **Frequency:** **Has patient had a splenectomy?** □ YES □ NO **Does patient have Hepatitis C infection currently being treated or to be treated with interferon-based therapy?** □ YES □ NO	**Is patient at increased risk of bleeding due to degree of thrombocytopenia and clinical condition?** □ YES □ NO **Does degree of thrombocytopenia prevent initiation of or ability to maintain interferon-based therapy?** □ YES □ NO **Does patient have a diagnosis of Severe Aplastic Anemia?** □ YES □ NO **Has patient had an insufficient response to immunosuppressive therapy?** □ YES □ NO		
Prescriber (or Staff) / Pharmacy Signature		Date	

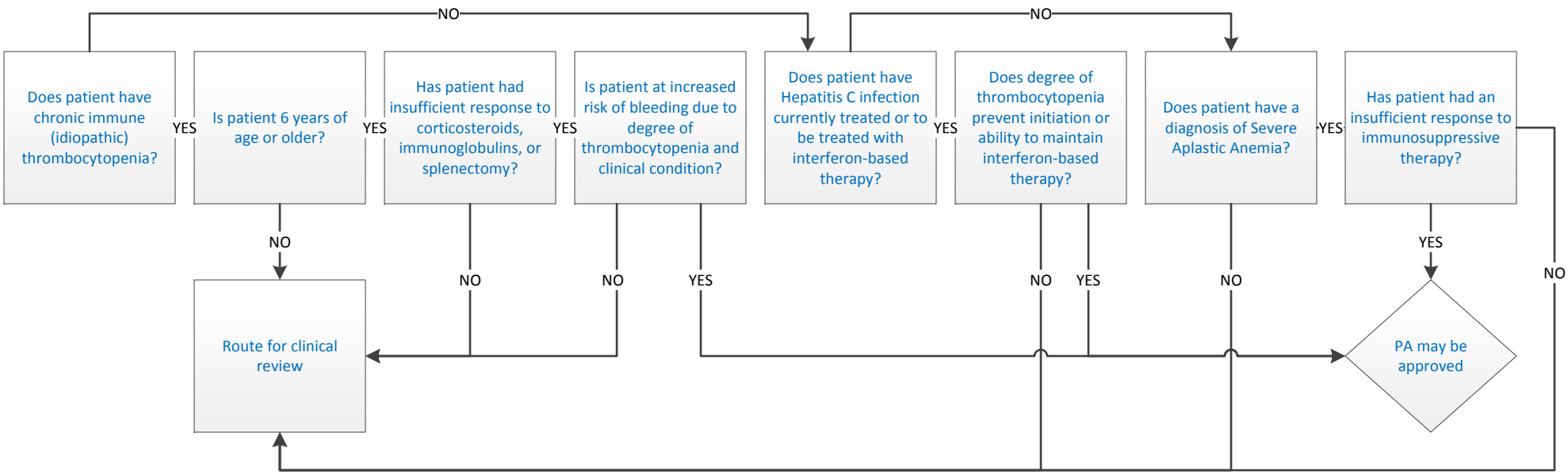
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Promacta Authorization Algorithm



health information designs

Prior Authorization Vendor for ND Medicaid

Provigil/Nuvigil
Prior Authorization

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 Provigil or Nuvigil must suffer from excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome, narcolepsy, or shift work disorder.

- **Provigil must be used before Nuvigil will be approved.**

Part I: TO BE COMPLETED BY PRESCRIBER

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: □ **Nuvigil** □ **Provigil**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED PROVIGIL (Nuvigil Requests)	START DATE: END DATE:	DOSE: FREQUENCY:	
□ EXCESSIVE SLEEPINESS ASSOCIATED WITH OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME □ NARCOLEPSY □ SHIFT WORK SLEEP DISORDER			
Prescriber (or Staff) / Pharmacy Signature		Date	

Part II: TO BE COMPLETED BY PHARMACY

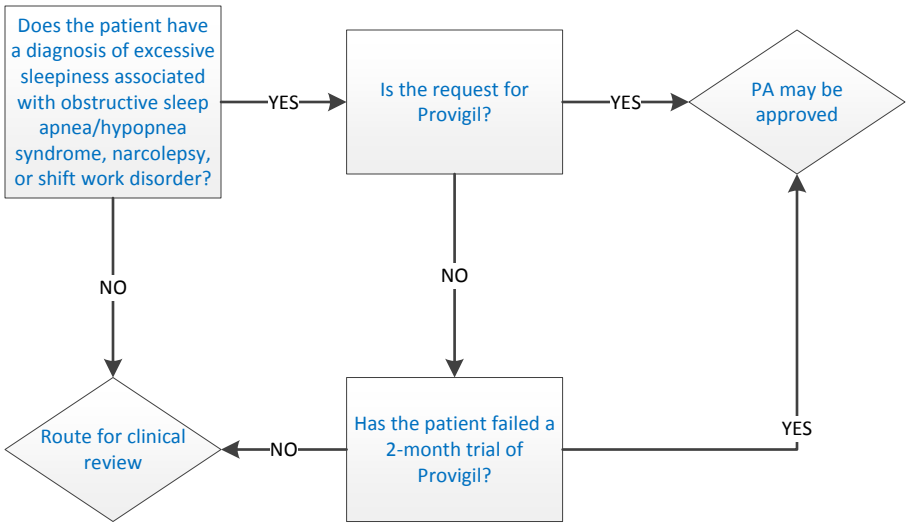
PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

Revised: 06/04/2015

North Dakota Department of Human Services
Provigil/Nuvigil Authorization Algorithm



health information designs

Pulmozyme
Prior Authorization

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 patients receiving a new prescription for Pulmozyme must meet the following criteria:

- *Patient must have a confirmed diagnosis of cystic fibrosis*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

QUALIFICATIONS FOR COVERAGE:

Requested Drug and Dosage: □ **Pulmozyme**	Diagnosis for this request:
Prescriber (or Staff) / Pharmacy Signature	Date

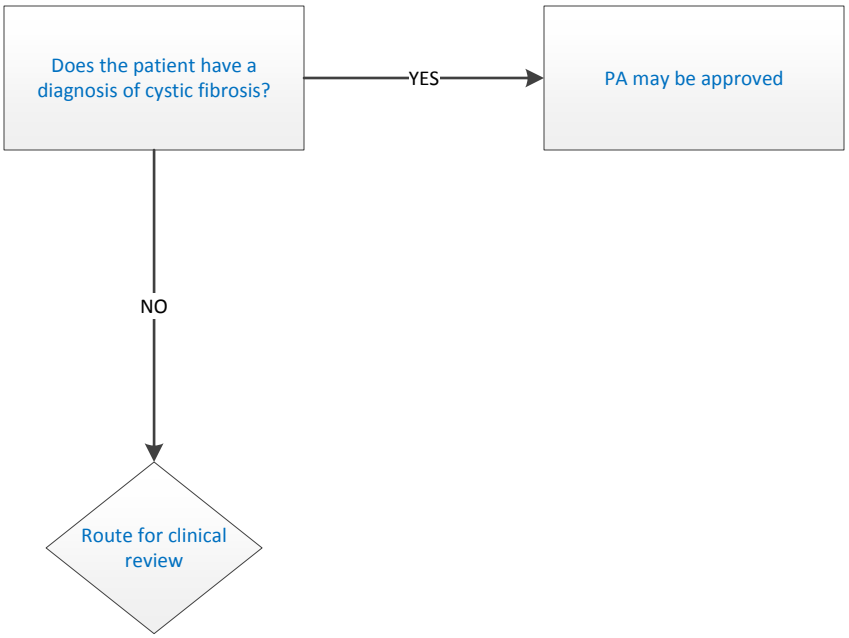
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Pulmozyme Authorization Algorithm



QUALAQUIN PA FORM

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

health information designs

Prior Authorization Vendor for ND Medicaid

ND Medicaid will cover Qualaquin with a diagnosis of Malaria.

Part I: TO BE COMPLETED BY PRESCRIBER

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	
PRESCRIBER NAME:	PRESCRIBER NPI:
Address:	Phone: ( )
City:	FAX: ( )
State: Zip:	

REQUESTED DRUG: □ **QUALAQUIN**	**Requested Dosage:** (must be completed)

Qualifications for coverage:

□ Diagnosis of malaria

□ *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 recipient.*

Prescriber (or Staff) / Pharmacy Signature: Date:

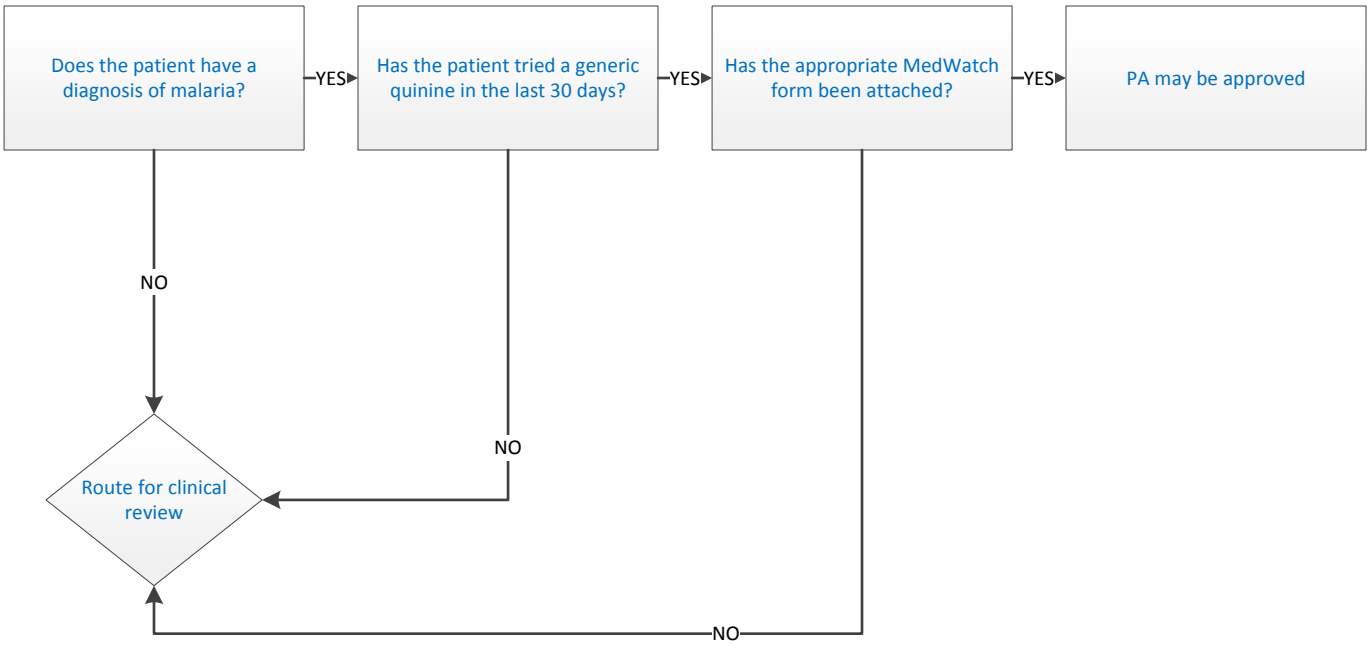
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Part III: FOR OFFICIAL USE ONLY

Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	

North Dakota Department of Human Services
Qualaquin Authorization Algorithm



RASUVO AND OTREXUP
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Rasuvo or Otrexup must meet the following criteria:

- **Patient must have an FDA approved indication for the medication requested.**
- **Patient must have tried and failed methotrexate.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		
Trial: **Start date:** **End date:** **Reason for failure:**			
Physician Signature		Date	

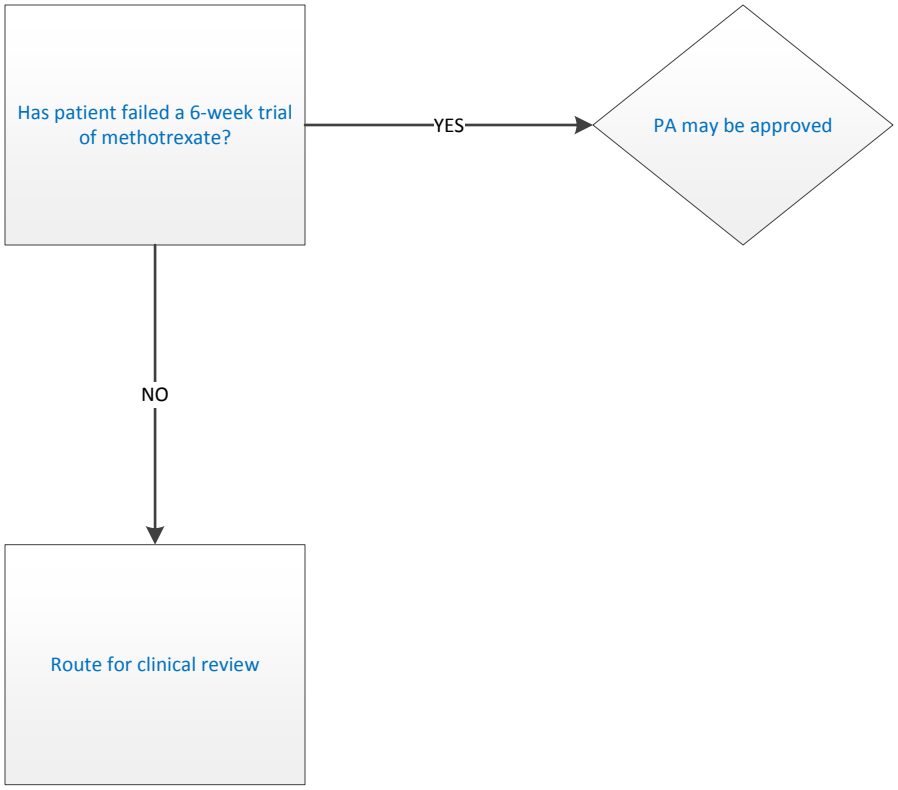
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Rasuvo and Otrexup Authorization Algorithm



health information designs

Rayos
Prior Authorization

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 patients receiving a new prescription for Rayos must meet the following criteria:

- *Patient must first try generic prednisone.*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

QUALIFICATIONS FOR COVERAGE:	
Requested Drug and Dosage: □ **Rayos**	Diagnosis for this request:
Prescriber (or Staff) / Pharmacy Signature	Date

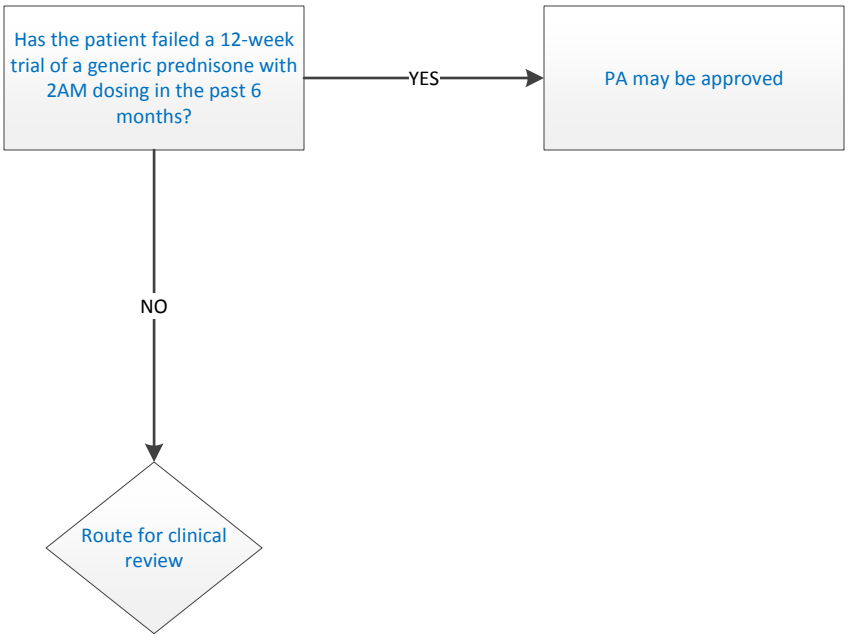
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Rayos Authorization Algorithm



health information designs

Relistor Prior Authorization

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 patients receiving a new prescription for Relistor must meet the following guidelines:

- Diagnosis of opioid-induced constipation
- Inability to tolerate oral medications *or*
- Failed two oral medications. Requires step therapy. See Relistor criteria for more information.

Note:
***Polyethylene glycol powder is covered without a prior authorization.**

Part I: TO BE COMPLETED BY PRESCRIBER

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: □ **Relistor**	**Diagnosis for this request:**		
Qualifications for coverage:			
FIRST FAILED MEDICATION	START DATE:	END DATE:	
SECOND FAILED MEDICATION	START DATE:	END DATE:	
□ INABILITY TO TOLERATE ORAL MEDICATIONS			
Prescriber (or Staff) / Pharmacy Signature		Date	

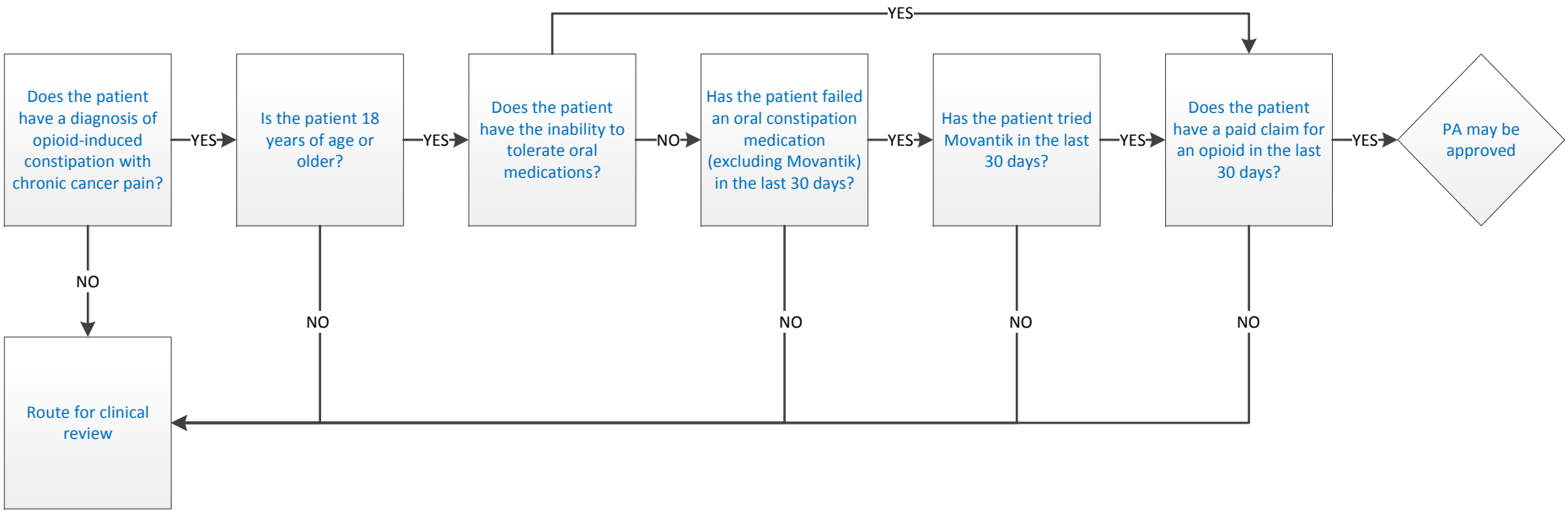
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Relistor Authorization Algorithm



RIBAPAK PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 RibaPak must meet the following criteria:

- **Patient must first try Ribavirin or Ribasphere.**

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ RIBAPAK	**FDA Approved Indication for this request:**		
□ **Failed therapy with Ribavirin or Ribasphere** Attach MedWatch	**Start Date**	**End Date**	**Dose**
WHAT IS THE HCV GENOTYPE? (I-IV)			
***TREATMENT WILL BE COVERED FOR 24 TO 48 WEEKS BASED UPON GENOTYPE AND DIAGNOSIS.**			
□ Treatment regimen for Hepatitis C will include pegylated or non-pegylated interferon in combination with oral ribavirin.			
Prescriber (or Staff) / Pharmacy Signature		Date	

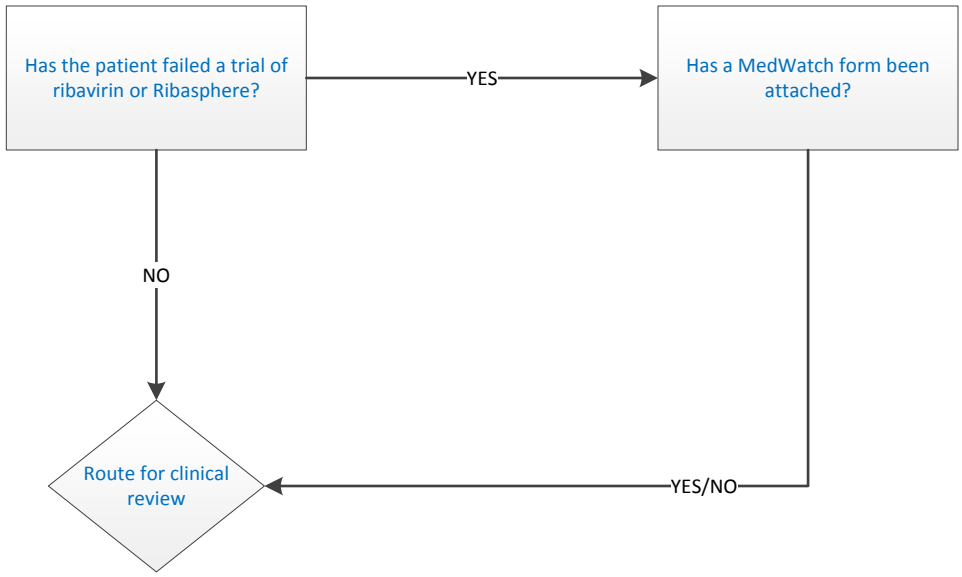
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Ribapak Authorization Algorithm



health information designs

Sancuso Prior Authorization

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 patients receiving a new prescription for Sancuso must be unable to take oral medications.
Note:

- ***Dolasetron, oral granisetron, and ondansetron do not require PA.***
- ***Patients must be unable to take oral medications or***
- ***Patients must fail therapy on ondansetron or oral granisetron before a PA may be granted.***

Part I: TO BE COMPLETED BY PRESCRIBER

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: □ **Sancuso**	**Diagnosis for this request:** **Does the patient have breast, head/neck, gastrointestinal, or gynecological cancer?** **Is the patient taking chemotherapy? If so, please list date of last chemotherapy treatment:**		
Qualifications for coverage:			
□ FAILED MEDICATION	START DATE: END DATE:	DOSE: FREQUENCY:	
□ PATIENT UNABLE TO TAKE ORAL MEDICATIONS			
Prescriber (or Staff) / Pharmacy Signature		Date	

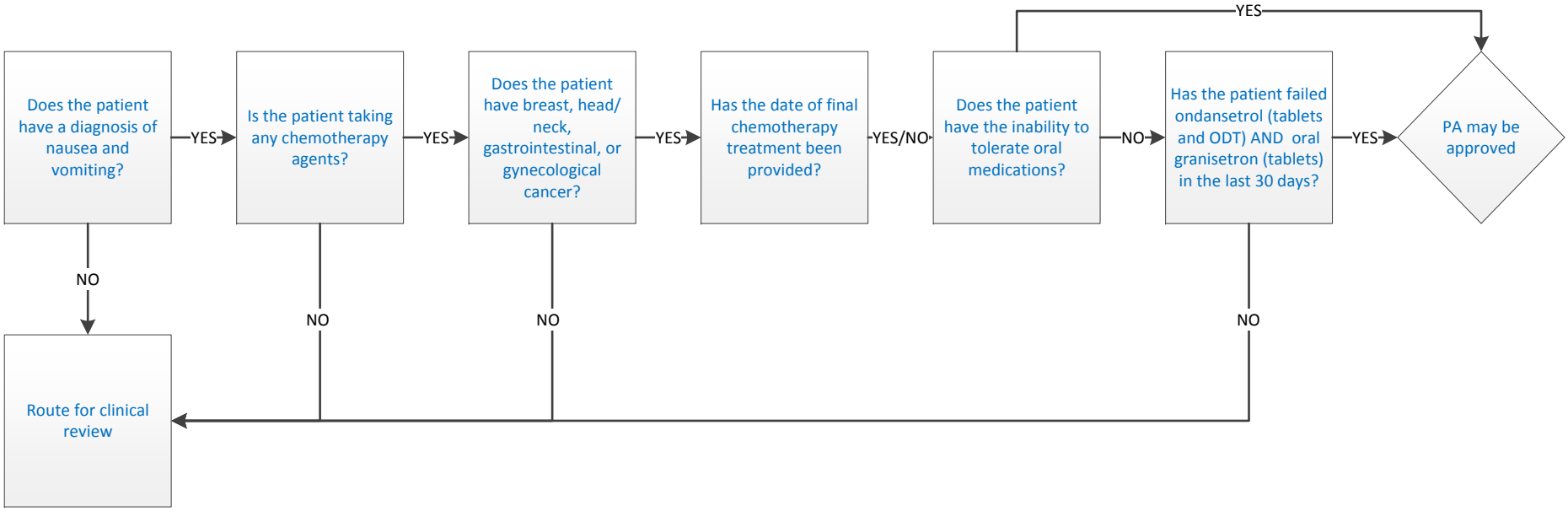
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Sancuso Authorization Algorithm



health information designs

Sedative/Hypnotic PA 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 patients receiving a new prescription for a name brand Sedative/Hypnotic must use Ambien® (zolpidem) as first line therapy.

Note:

- **Requires step therapy. See Sedative/Hypnotic PA criteria for more information.**

Part I: TO BE COMPLETED BY PHYSICIAN

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:	**Diagnosis for this request:**		

Qualifications for coverage:

□ Failed Medications (list all)

Have other conditions causing sleep issues been ruled out?	□ YES □ NO
Does the patient require dose tapering?	□ YES □ NO
Is the patient's insomnia characterized by difficulty with sleep maintenance?	□ YES □ NO
Is the patient's insomnia characterized by difficulty with sleep initiation?	□ YES □ NO
Is the patient's insomnia characterized by difficulty with middle of the night awakening with more than 4 hours left to sleep?	□ YES □ NO

□ 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 recipient.*

Prescriber (or Staff) / Pharmacy Signature	Date

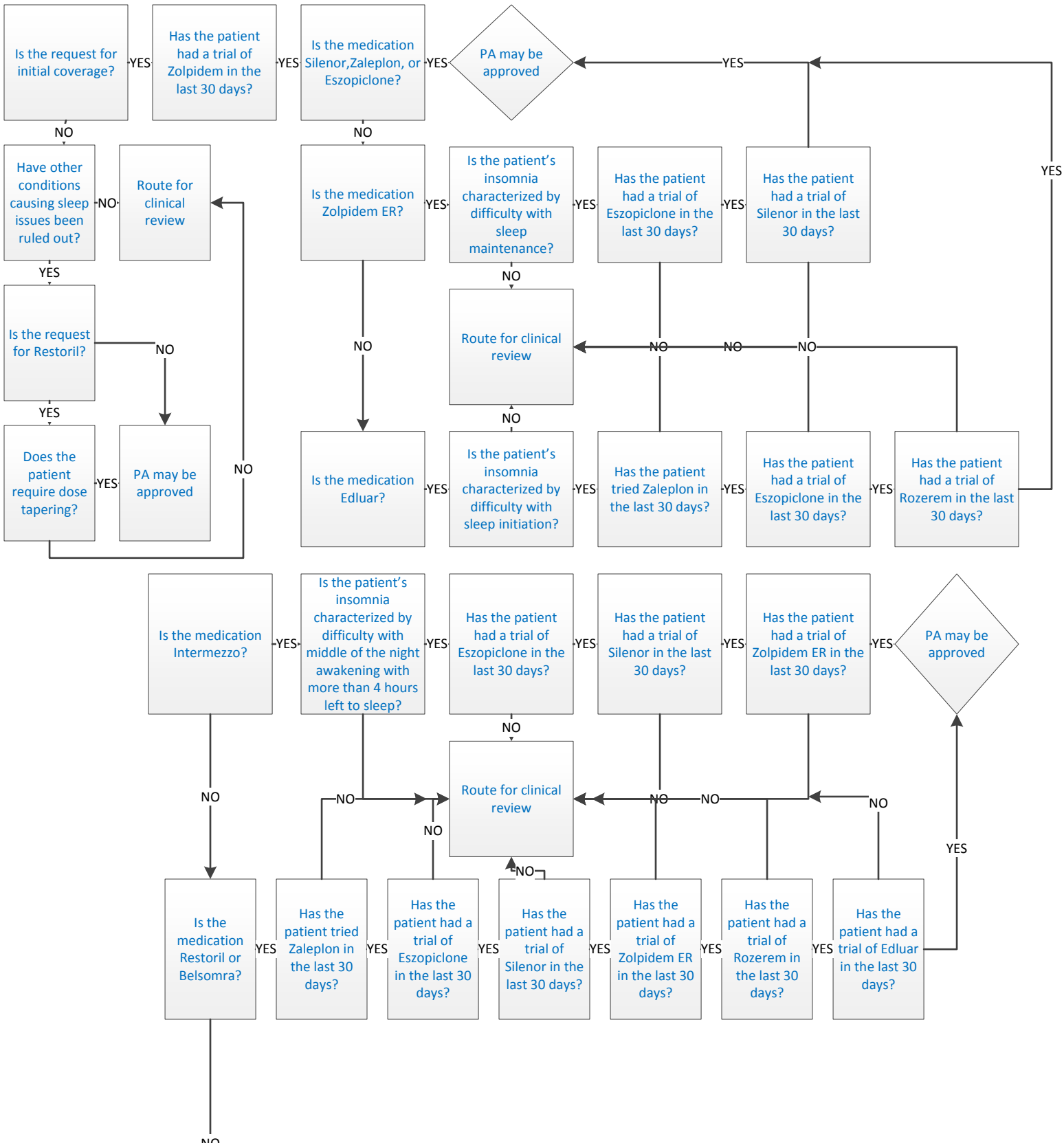
Part II: TO BE COMPLETED BY PHARMACY

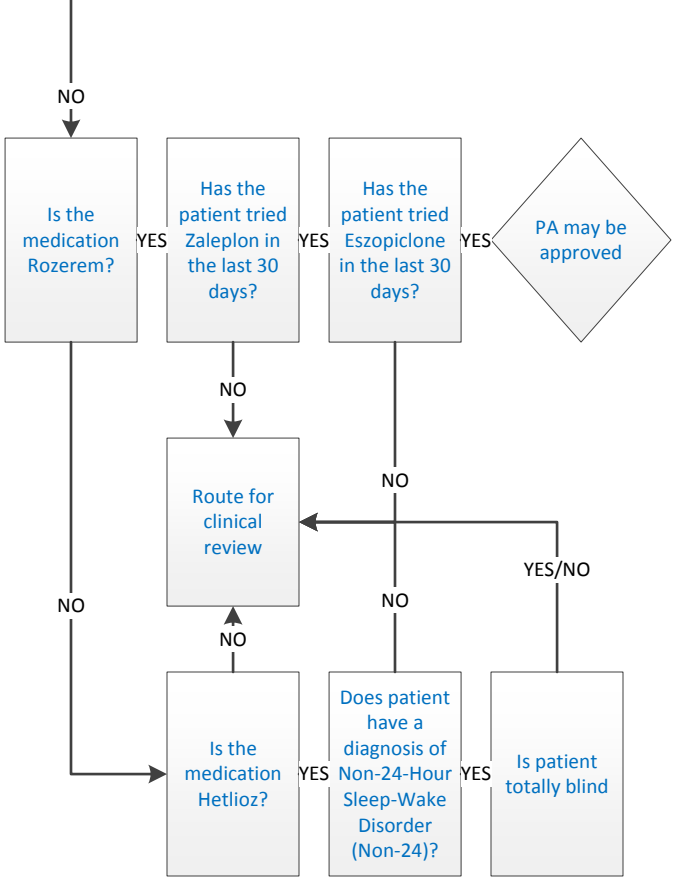
PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Sedative/Hypnotics Authorization Algorithm




NO
Is the medication Rozerem?
YES
Has the patient tried Zaleplon in the last 30 days?
YES
Has the patient tried Eszopiclone in the last 30 days?
YES
PA may be approved
NO
Route for clinical review
NO
YES/NO
NO
NO
NO
Is the medication Hetlioz?
YES
Does patient have a diagnosis of Non-24-Hour Sleep-Wake Disorder (Non-24)?
YES
Is patient totally blind

SEROMYCIN
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Seromycin must meet the following criteria:

- **Patient must have a diagnosis of tuberculosis.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		
Physician Signature		Date	

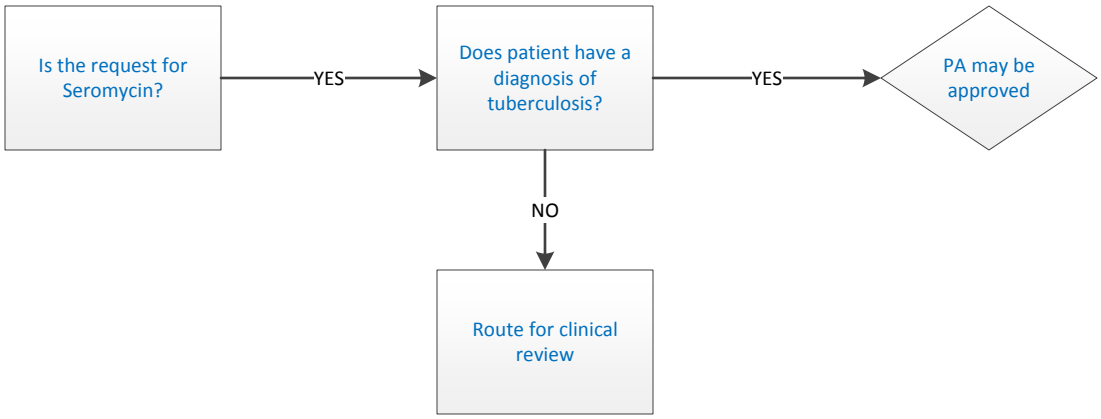
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Seromycin Authorization Algorithm



Short-Acting HFA Beta$_2$ Agonist PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 ProAir Respiclick, ProAir HFA, Ventolin HFA, or Xopenex HFA must use Proventil HFA as first line therapy.

***Note: Proventil HFA does not require a prior authorization.**

- **Ventolin HFA – trial of Proventil HFA.**
- **Xopenex HFA – trial of Proventil HFA and Ventolin HFA.**
- **ProAir HFA and ProAir RespiClick – trial of Proventil HFA, Ventolin HFA, and Xopenex HFA.**

Part I: TO BE COMPLETED BY PHYSICIAN

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:	**Diagnosis for this request:**
□ XOPENEX HFA □ VENTOLIN HFA □ PROAIR HFA/PROAIR RESPICLICK	

Qualifications for coverage:

Failed therapy	Start Date	End Date	Dose	Frequency
1. 2. 3.				

□ *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 recipient.*

Prescriber (or Staff) / Pharmacy Signature	Date

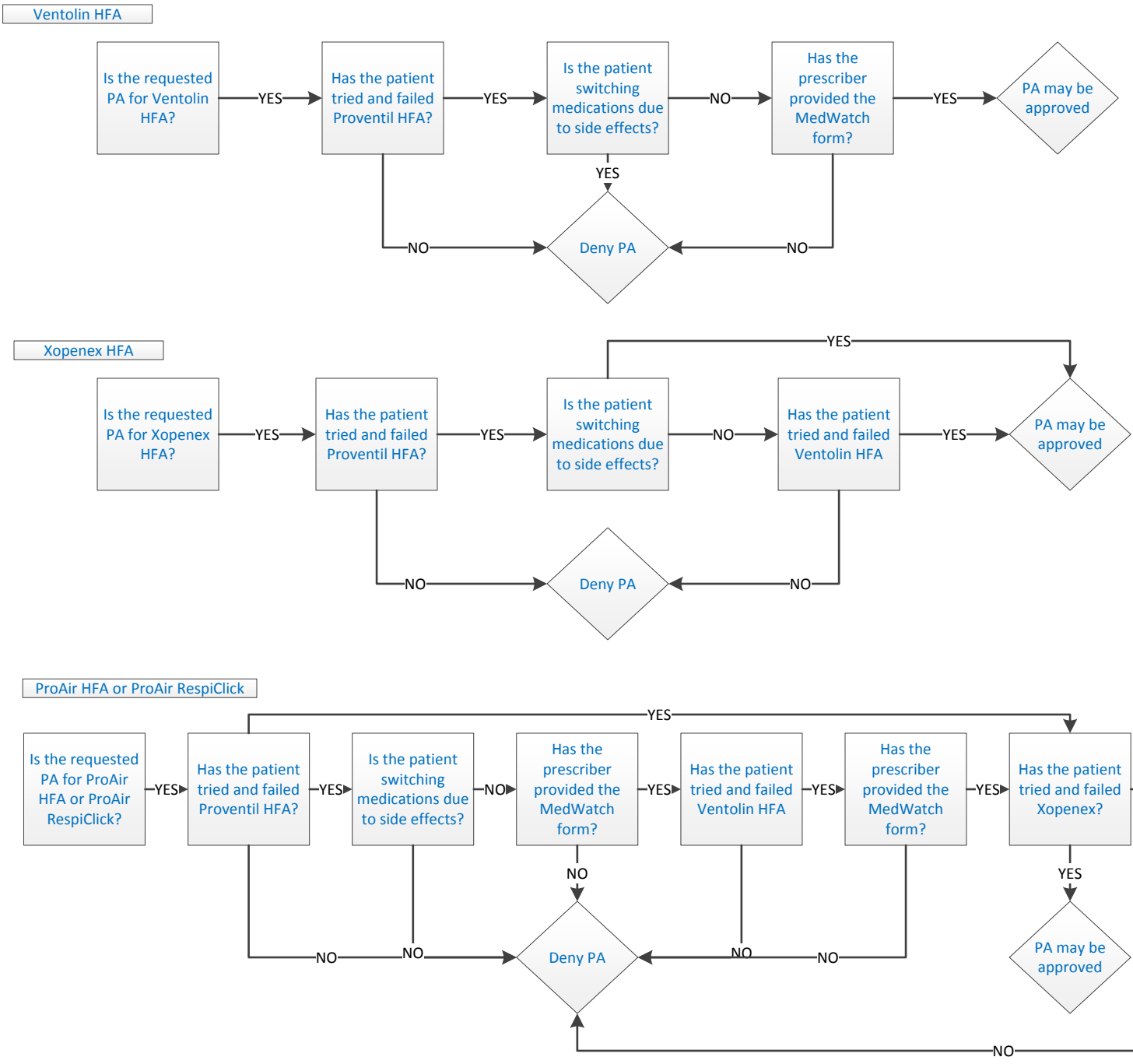
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Short-Acting HFA Beta2 Agonists Authorization Algorithm



SOVALDI PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Sovaldi must meet the following criteria:

- Patient must be ≥ 18 years old.
- Must have a diagnosis of chronic hepatitis C (genotypes 1, 2, 3, or 4) with compensated liver disease.
- Liver biopsy showing fibrosis corresponding to a Metavir score of greater than or equal to 2 or Ishak score of greater than or equal to 3 or other accepted test demonstrating liver fibrosis.
- Must be prescribed by or in consultation with a hepatologist, gastroenterologist, or infectious disease specialist.
- Must be used in combination with ribavirin or in combination with pegylated interferon and ribavirin. **(must not be used as monotherapy)**
- Female patients must have a negative pregnancy test within 30 days prior to initiation of therapy and monthly during treatment.
- Absence of renal impairment (eGFR must be >30mL/min/1.73m^2) and absence of end stage renal disease (ESRD).
- Documentation showing that patient is drug and alcohol free for the past 12 months

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name		Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name		Specialist involved in therapy		
Prescriber NPI		Telephone Number	Fax Number	
Address		City	State	Zip Code
Requested Drug □ **Sovaldi** Dosage _____	**Documented liver fibrosis**	**Diagnosis for this request** **Genotype** **Pegylated interferon dose** **Ribavirin dose**	**Patient is drug and alcohol free for past 12 months** □ YES □ NO **Negative pregnancy test in the past 30 days** □ YES □ NO	**eGFR**
Has the patient been previously treated for chronic hepatitis C? □ YES □ NO If yes, please indicate past treatment regimen(s), dates of treatment, and response to therapy:			Baseline HCV RNA: HCV RNA 4 weeks after starting therapy:	
Prescriber (or Staff) / Pharmacy Signature			Date	

Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

Hepatitis C Patient Consent Form

I, _____, have been counseled by my healthcare provider on the following:

- ☐ I agree to complete the entire course of treatment and have laboratory tests before starting, during, and after completing treatment as ordered by my healthcare provider.
- ☐ I understand that for the medication to work, it is important that I take my medication each day for the entire course of treatment.
- ☐ I understand the importance to not drink alcohol or use illicit drugs during and after my treatment for Hepatitis C.
- ☐ I understand how to avoid being re-infected with Hepatitis C during and after my treatment.
- ☐ (Females) I understand that these drugs are harmful to babies. I will use two methods to avoid getting pregnant. I understand that this medication may cause serious birth defects to an unborn child for up to 6 months after I have completed my treatment.
- ☐ (Males) I understand that while I am taking the medication, I must avoid getting my partner pregnant. If my partner becomes pregnant, the baby may have serious birth defects. My partner and I will prevent pregnancy using two forms of birth control for up to 6 months after my treatment is complete. If I have a committed partner, I have discussed these risks with her.

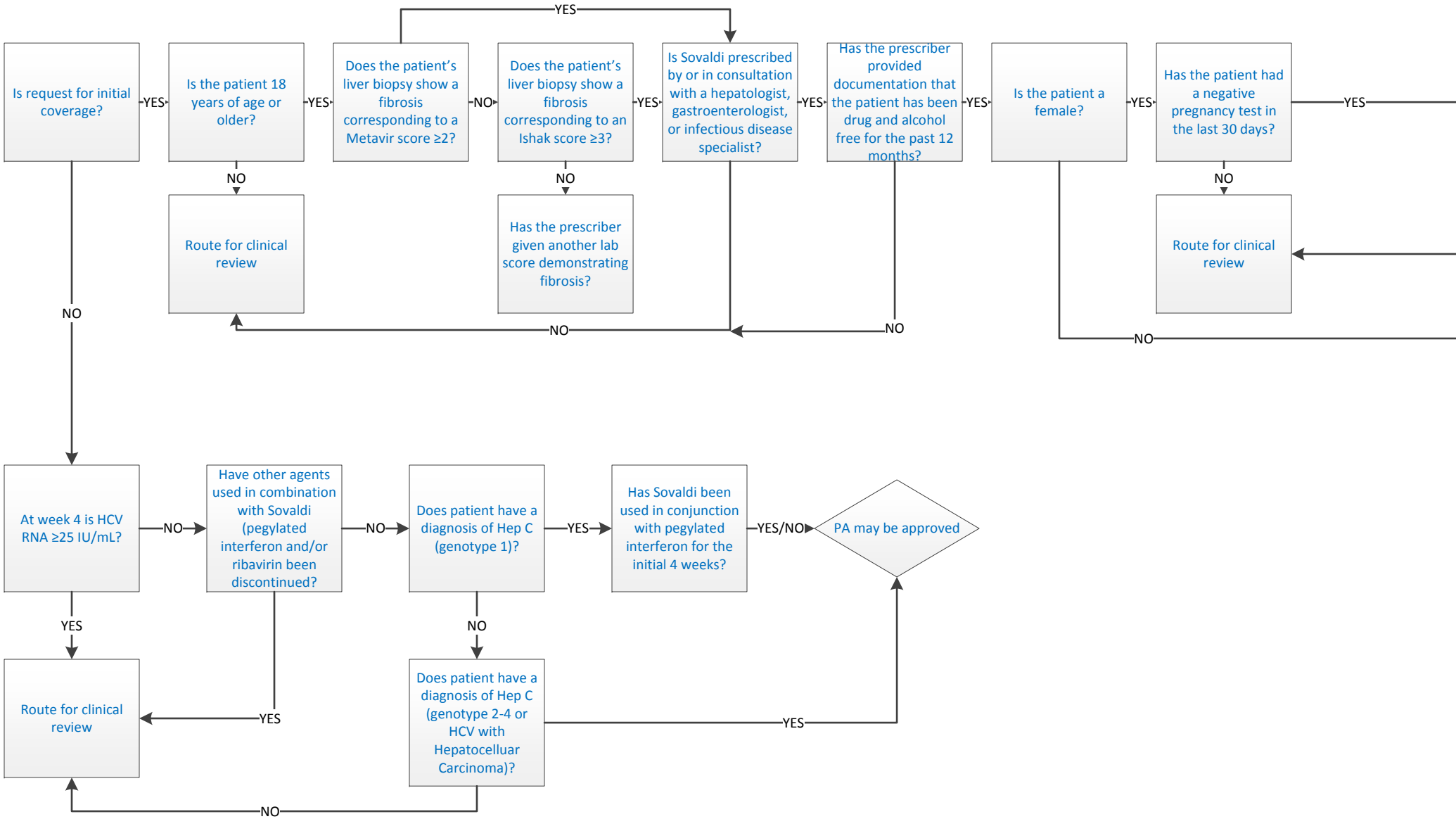
Patient Signature _____ Date __/__/____

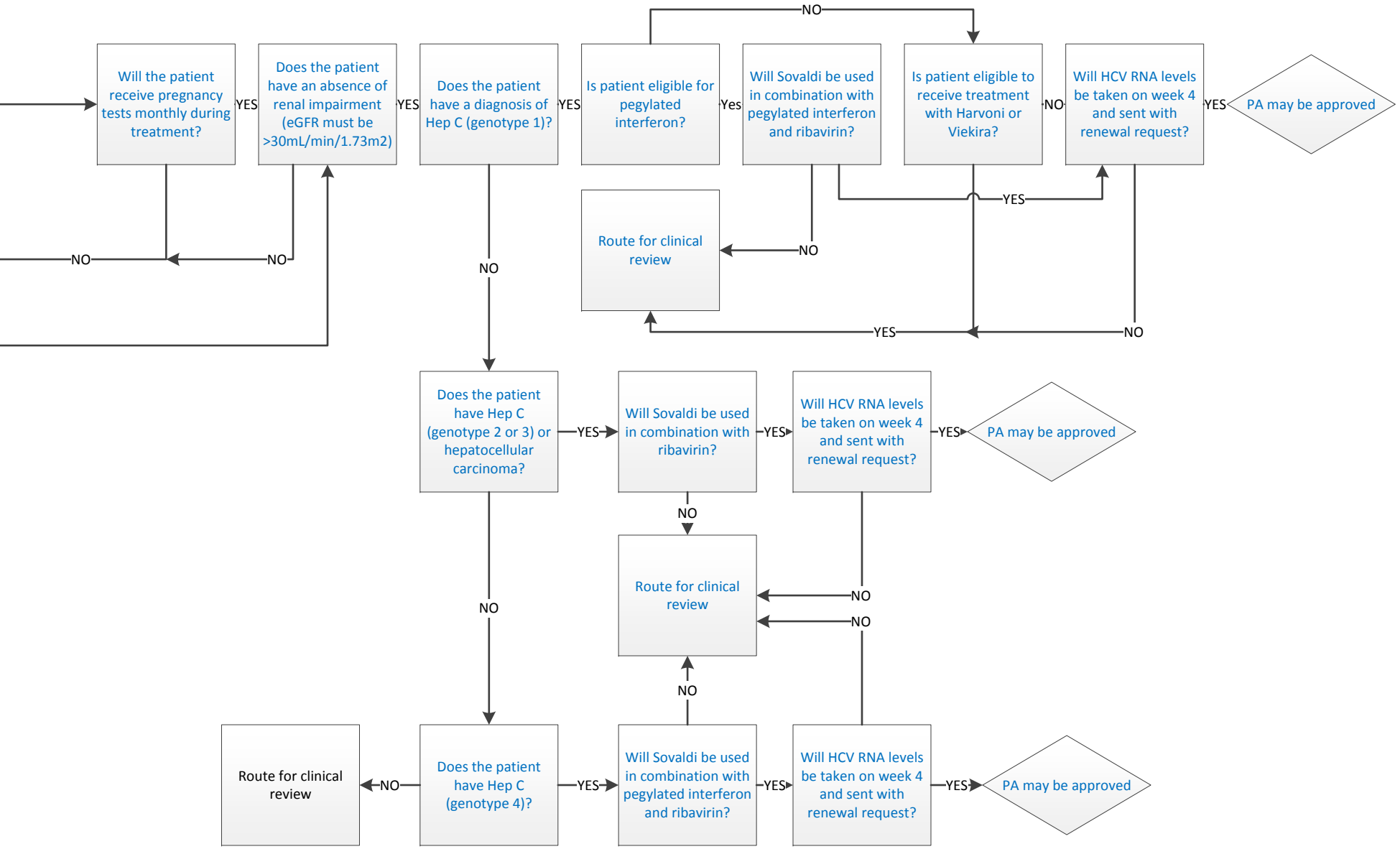
Pharmacy or Prescriber Representative:

Signature _____ Date __/__/____

By signature, the pharmacy or prescriber representative confirms the contract has been reviewed with the patient.

North Dakota Department of Human Services
Sovaldi Authorization Algorithm




Will the patient receive pregnancy tests monthly during treatment?
YES
Does the patient have an absence of renal impairment (eGFR must be >30mL/min/1.73m2)
YES
Does the patient have a diagnosis of Hep C (genotype 1)?
YES
Is patient eligible for pegylated interferon?
Yes
Will Sovaldi be used in combination with pegylated interferon and ribavirin?
Is patient eligible to receive treatment with Harvoni or Viekira?
NO
Will HCV RNA levels be taken on week 4 and sent with renewal request?
YES
PA may be approved
NO
NO
NO
Route for clinical review
NO
YES
YES
NO
NO
Does the patient have Hep C (genotype 2 or 3) or hepatocellular carcinoma?
YES
Will Sovaldi be used in combination with ribavirin?
YES
Will HCV RNA levels be taken on week 4 and sent with renewal request?
YES
PA may be approved
NO
Route for clinical review
NO
NO
NO
NO
Route for clinical review
NO
Does the patient have Hep C (genotype 4)?
YES
Will Sovaldi be used in combination with pegylated interferon and ribavirin?
YES
Will HCV RNA levels be taken on week 4 and sent with renewal request?
YES
PA may be approved

health information designs

Statins
Prior Authorization

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 who are prescribed a name-brand statin must first try a generic statin.

- *Requires step therapy. See statin criteria for more information.*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

QUALIFICATIONS FOR COVERAGE:

Requested Drug and Dosage:	Diagnosis for this request:
Medication Failed and Dose (list all)	
Is the statin intensity treatment goal low, moderate, or high? _____	
Prescriber (or Staff) / Pharmacy Signature	Date

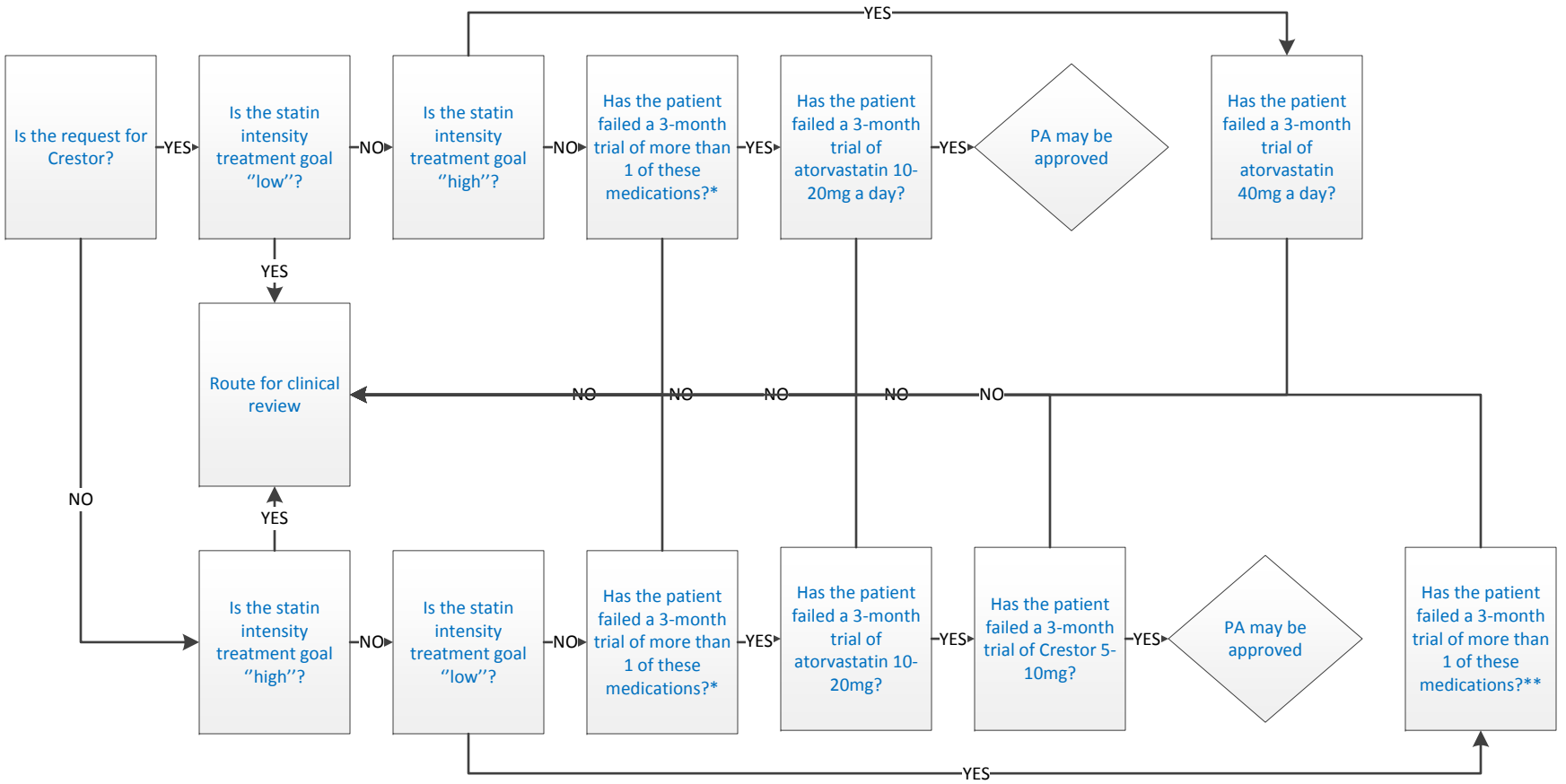
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Statins Authorization Algorithm



*Simvastatin 20-40mg a day; Pravastatin 40-80mg a day; Lovastatin 40mg a day; Fluvastatin XL 80mg a day; Fluvastatin 40mg twice a day

**Simvastatin 10mg a day; Pravastatin 10-20mg a day; Lovastatin 20mg a day; Fluvastatin 20- 40mg twice a day

SUBOXONE/SUBUTEX PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Suboxone and Subutex must meet the following criteria:

- **Patient must be 16 years or older.**
- **Indicated for use in treatment of documented opioid dependence.**
- **Must not be taking other opioids, tramadol, or carisoprodol concurrently.**
- **Prescriber must be registered to prescribe Suboxone/Subutex under the Substance Abuse and Mental Health Services Administration (SAMHSA).**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name	**(SAMHSA ID-X DEA Number)**		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ BUPRENORPHINE/NALOXONE □ZUBSOLV □ SUBUTEX □ SUBOXONE FILM □ BUNAVAIL	**FDA Approved Indication for this request:**		
□ Patient is not taking other opioids, tramadol, or carisoprodol concurrently with requested medication.			
Has a contract between the prescriber and patient been signed? □ YES □ NO Does the prescriber perform routine drug screens? □ YES □ NO Does the prescriber routinely check the PDMP system? □ YES □ NO Has the prescriber provided the PDMP reports for the last 3 months? □ YES □ NO	Is the patient pregnant? □YES □NO Patient's due date:		
Prescriber (or Staff) / Pharmacy Signature	Date		

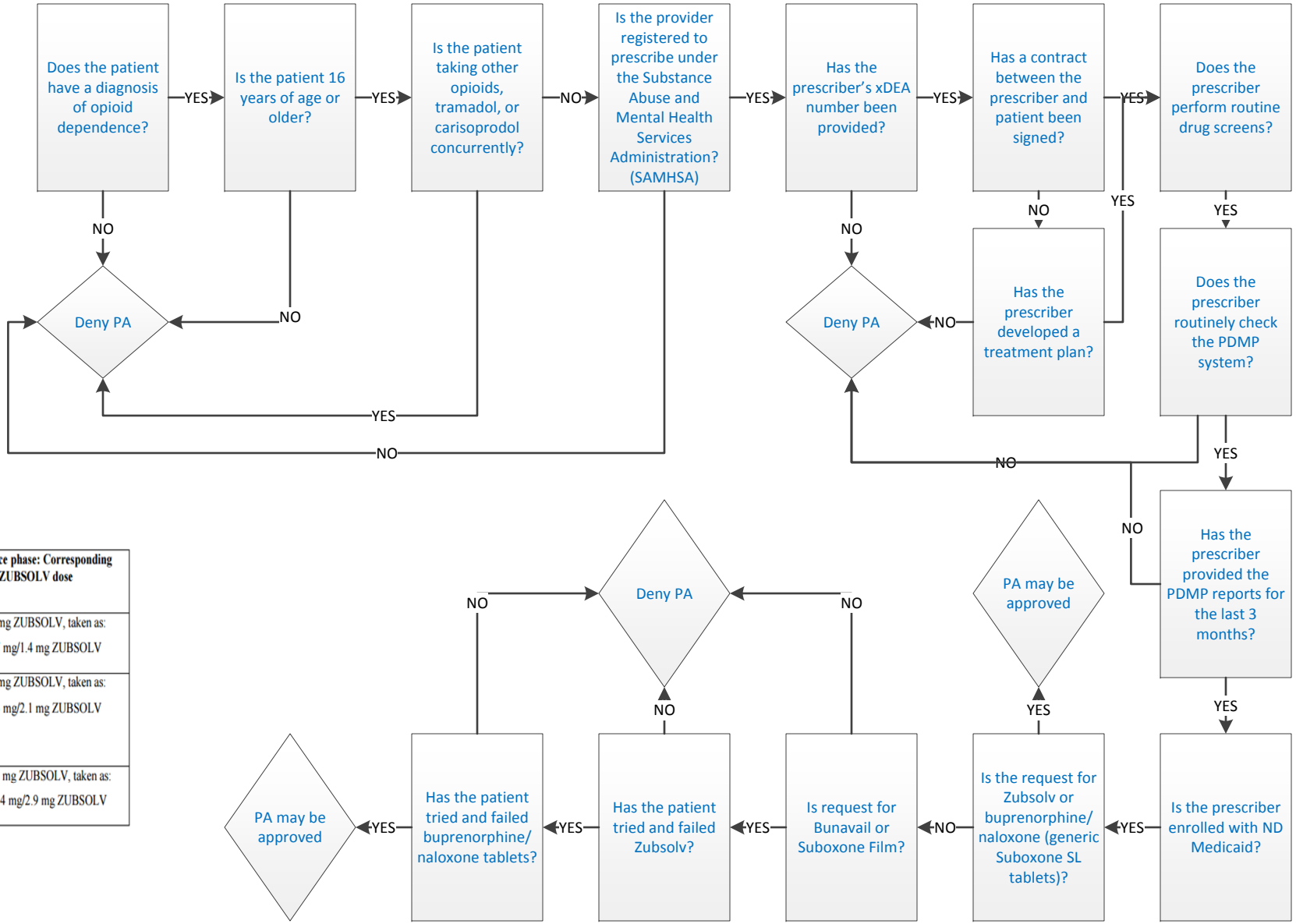
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

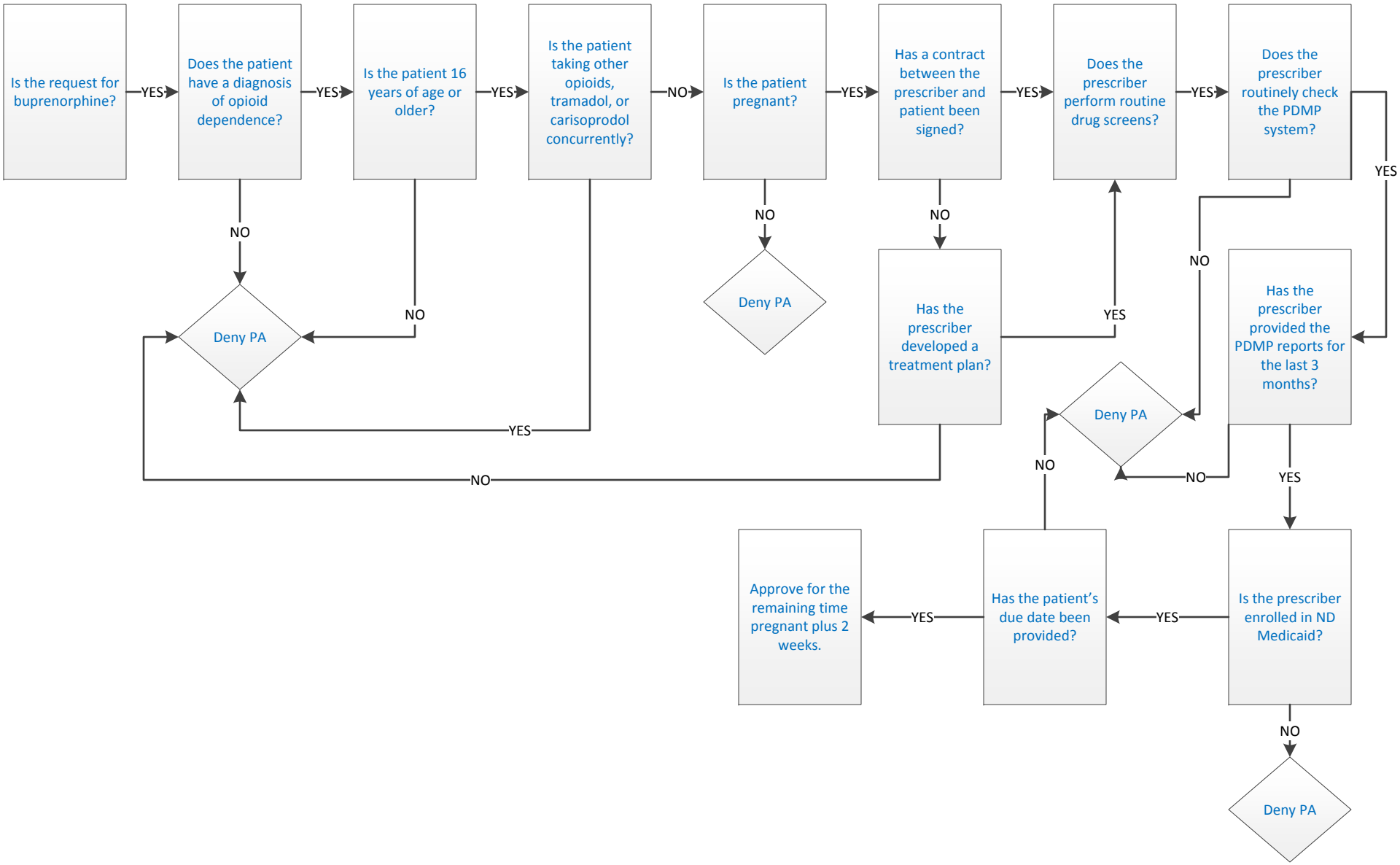
Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Buprenorphine/Naloxone Combinations Authorization Algorithm



Induction phase: Final sublingual buprenorphine dose	Maintenance phase: Corresponding sublingual ZUBSOLV dose
8 mg buprenorphine, taken as: • One 8 mg buprenorphine tablet	5.7 mg/1.4 mg ZUBSOLV, taken as: • One 5.7 mg/1.4 mg ZUBSOLV tablet
12 mg buprenorphine, taken as: • One 8 mg buprenorphine tablet AND • Two 2 mg buprenorphine tablets	8.6 mg/2.1 mg ZUBSOLV, taken as: • One 8.6 mg/2.1 mg ZUBSOLV tablet
16 mg buprenorphine, taken as: • Two 8 mg buprenorphine tablets	11.4 mg/2.9 mg ZUBSOLV, taken as: • One 11.4 mg/2.9 mg ZUBSOLV tablet

North Dakota Department of Human Services
Buprenorphine/Naloxone Combinations Authorization Algorithm



health information designs

Tecfidera Prior Authorization

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 patients who are prescribed Tecfidera must follow these guidelines:

Note:

- ***Must have relapsing forms of multiple sclerosis.***
- ***Must have a recent CBC (within 6 months).***
- ***Requires step therapy. See Tecfidera criteria for more information.***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist Involved in Therapy		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Tecfidera**	**Diagnosis for this request:** **Current CBC (date):**		
FAILED THERAPY (LIST ALL):	**Start Date:** **End Date:**		
Prescriber (or Staff) / Pharmacy Signature		Date	

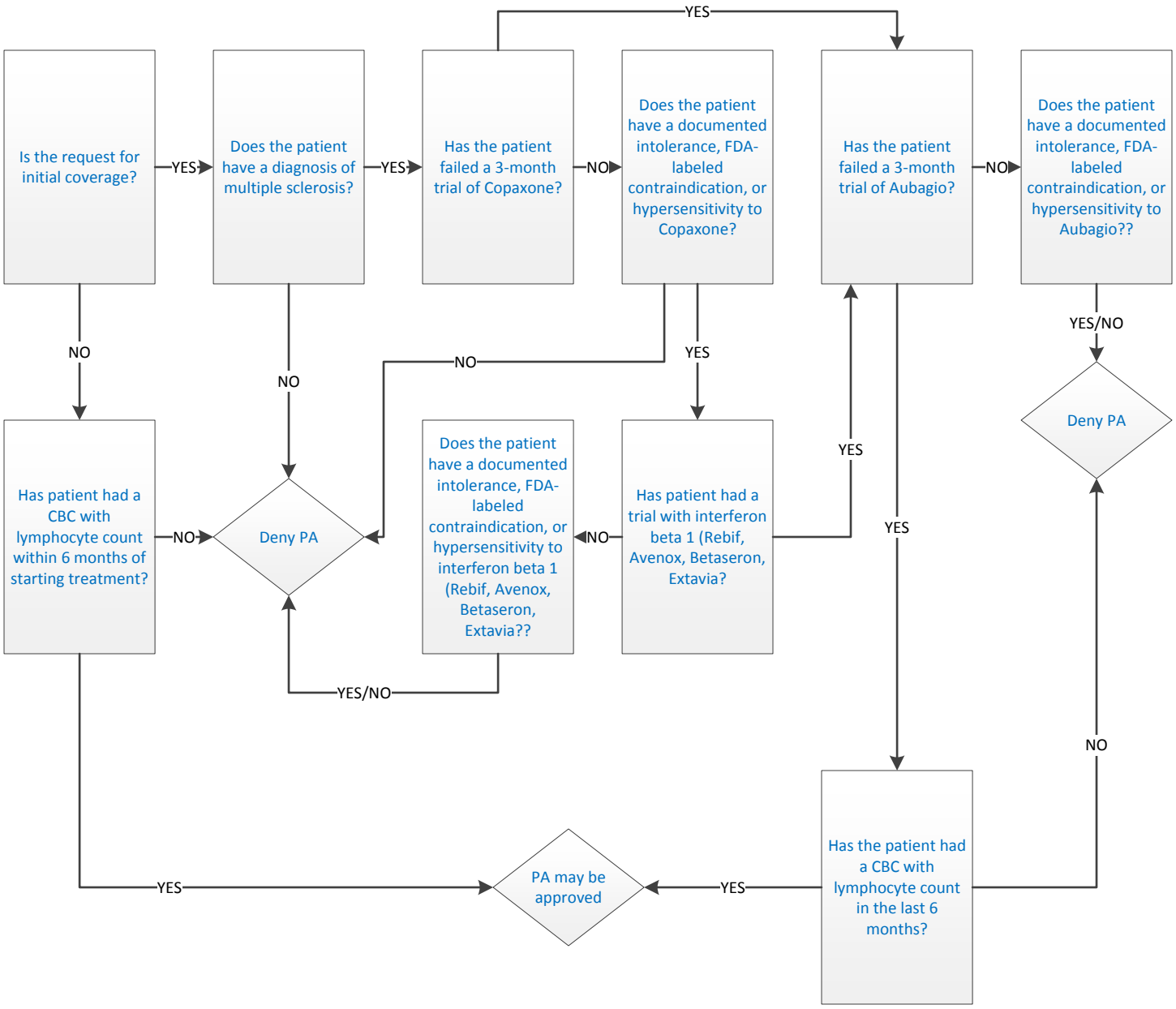
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Tecfidera Authorization Algorithm



TECHNIVIE PA FORM

health information designs

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 patients receiving a new prescription for Technivie must meet the following criteria:

- Patient must be ≥ 18 years old.
- Must have a diagnosis of chronic hepatitis C (genotype 4).
- Liver biopsy showing fibrosis corresponding to a Metavir score of greater than or equal to 2 or Ishak score of greater than or equal to 3 or other accepted test demonstrating liver fibrosis.
- Must be prescribed by or in consultation with a hepatologist, gastroenterologist, or infectious disease specialist.
- Patient must have absence of moderate or severe hepatic impairment.
- Documentation showing that patient is drug and alcohol free for the past 12 months
- The concomitant use of Technivie and moderate/strong inducers of CYP3A is contraindicated.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug □ **Technivie** Dosage: _____	**Documented liver fibrosis:** **Does the patient have cirrhosis?** □ YES □ NO	**Diagnosis for this request:** **Genotype:**	**Patient is drug and alcohol free for past 12 months:** □ YES □ NO *PROVIDE DOCUMENTATION **Ribavirin dose:**

Has the patient been previously treated for chronic hepatitis C? □ YES □ NO If yes, please indicate past treatment regimen(s), dates of treatment, and response to therapy: Has patient attested that they will continue treatment without interruption for the duration of therapy? □ YES □ NO Is the patient taking Technivie in combination with ribavirin? □ YES □ NO If yes has the patient had a negative pregnancy test? □ YES □ NO If patient is not taking Technivie in combination with ribavirin, give rationale:_____ Is the patient taking Technivie in combination with moderate/strong inducers of CYP3A? □ YES □ NO Does the patient have moderate/severe hepatic impairment? □ YES □ NO	Baseline HCV RNA: HCV RNA 4 weeks after starting therapy: Metavir Score: Ishak Score:
Prescriber (or Staff) / Pharmacy Signature	Date

Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

Hepatitis C Patient Consent Form

I, _____, have been counseled by my healthcare provider on the following:

- ☐ I agree to complete the entire course of treatment and have laboratory tests before starting, during, and after completing treatment as ordered by my healthcare provider.
- ☐ I understand that for the medication to work, it is important that I take my medication each day for the entire course of treatment.
- ☐ I understand the importance to not drink alcohol or use illicit drugs during and after my treatment for Hepatitis C.
- ☐ I understand how to avoid being re-infected with Hepatitis C during and after my treatment.
- ☐ (Females) I understand that these drugs are harmful to babies. I will use two methods to avoid getting pregnant. I understand that this medication may cause serious birth defects to an unborn child for up to 6 months after I have completed my treatment.
- ☐ (Males) I understand that while I am taking the medication, I must avoid getting my partner pregnant. If my partner becomes pregnant, the baby may have serious birth defects. My partner and I will prevent pregnancy using two forms of birth control for up to 6 months after my treatment is complete. If I have a committed partner, I have discussed these risks with her.

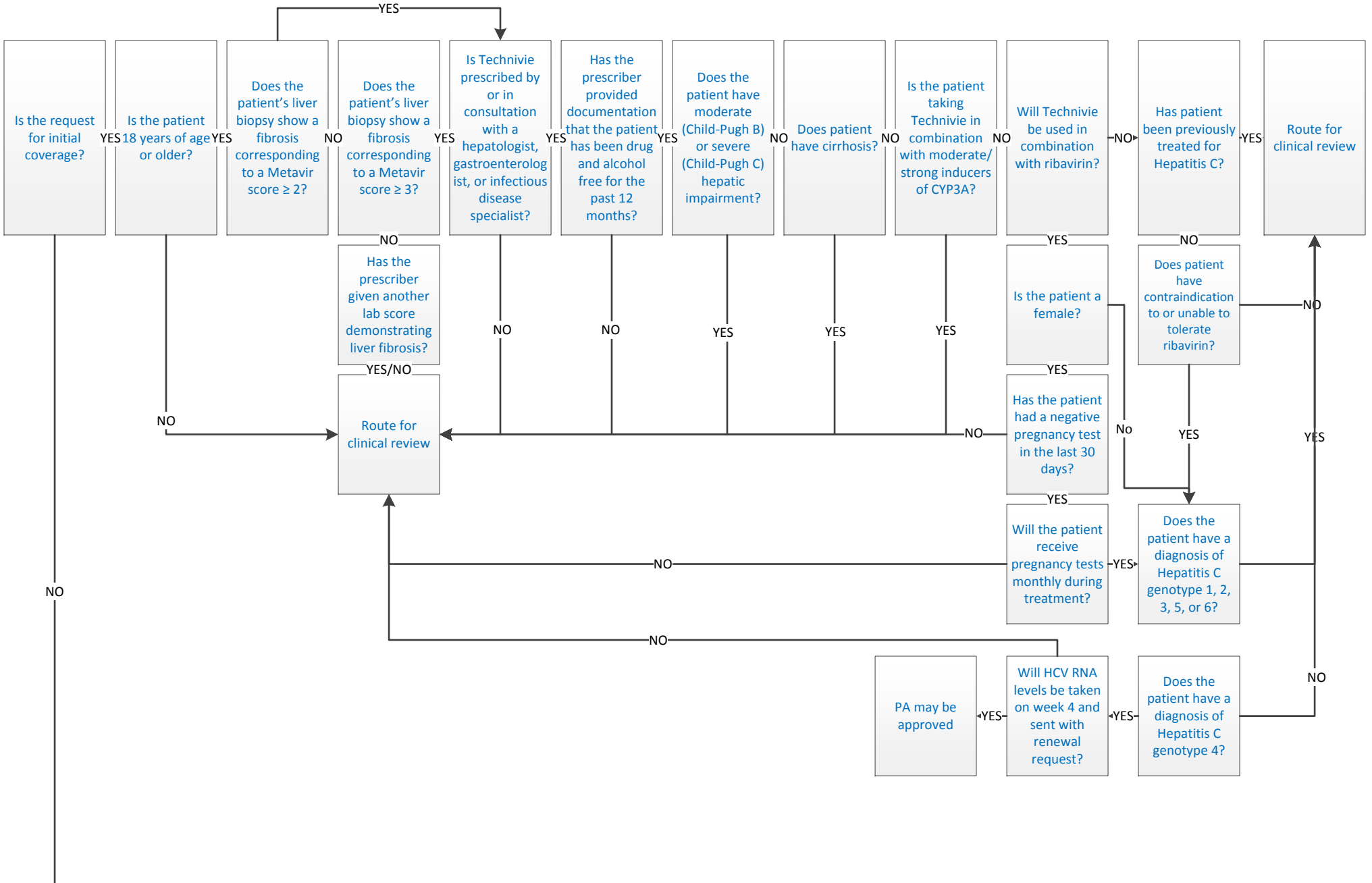
Patient Signature _____ Date __/__/____

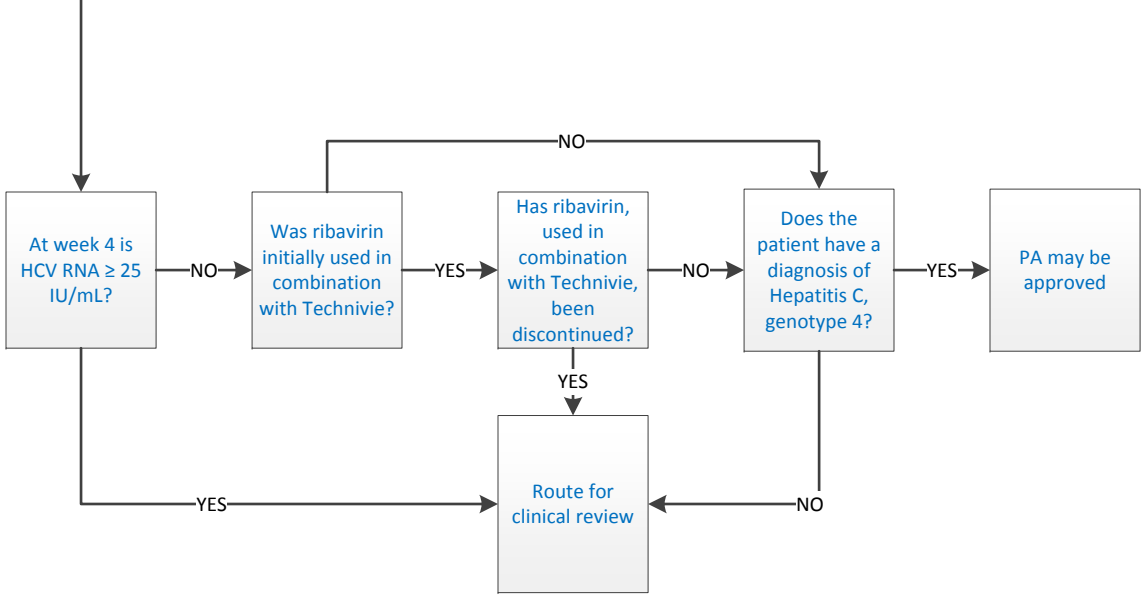
Pharmacy or Prescriber Representative:

Signature _____ Date __/__/____

By signature, the pharmacy or prescriber representative confirms the contract has been reviewed with the patient.

North Dakota Department of Human Services
Technivie Authorization Algorithm




At week 4 is HCV RNA ≥ 25 IU/mL?
NO
Was ribavirin initially used in combination with Technivie?
YES
Has ribavirin, used in combination with Technivie, been discontinued?
NO
Does the patient have a diagnosis of Hepatitis C, genotype 4?
YES
PA may be approved
NO
YES
YES
Route for clinical review
NO

TOPICAL TESTOSTERONE
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 a topical testosterone must meet the following criteria:

- **Patient must have an FDA approved indication.**

Part I: TO BE COMPLETED BY PHYSICIAN

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:	**Diagnosis for this Request:**
□ ANDRODERM_____ □ ANDROGEL_____ □ FORTESTA_____ □ TESTIM_____ □ AXIRON_____ □ VOGELXO_____	**Testosterone Level:** **Date:**

□ *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 recipient.*

Prescriber (or Staff) / Pharmacy Signature	Date

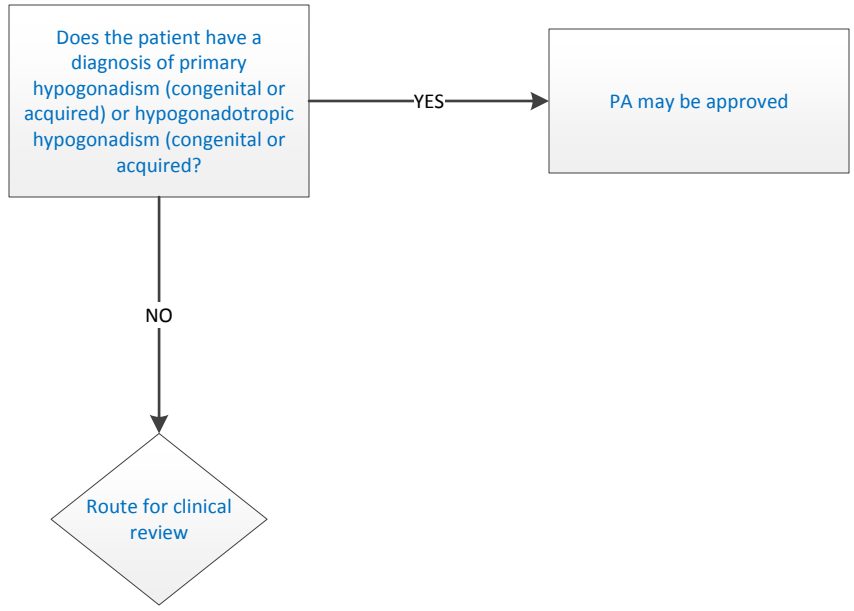
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Topical Testosterone Agents Authorization Algorithm



TARGETED IMMUNE MODULATORS PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Actemra, Orencia, Humira, Enbrel, Kineret, Cimzia, Cosentyx, Simponi, and Stelara must submit a prior authorization form.

- Prior authorization will be granted if the requested product has been approved by the FDA for the indication listed below.

Part I: TO BE COMPLETED BY PHYSICIAN

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:**
□ ORENCIA □ ACTEMRA □ ENBREL □ CIMZIA □ KINERET □ COSENTYX □ HUMIRA □ SIMPONI □ STELARA	

□ *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 recipient.*

Prescriber (or Staff) / Pharmacy Signature	Date

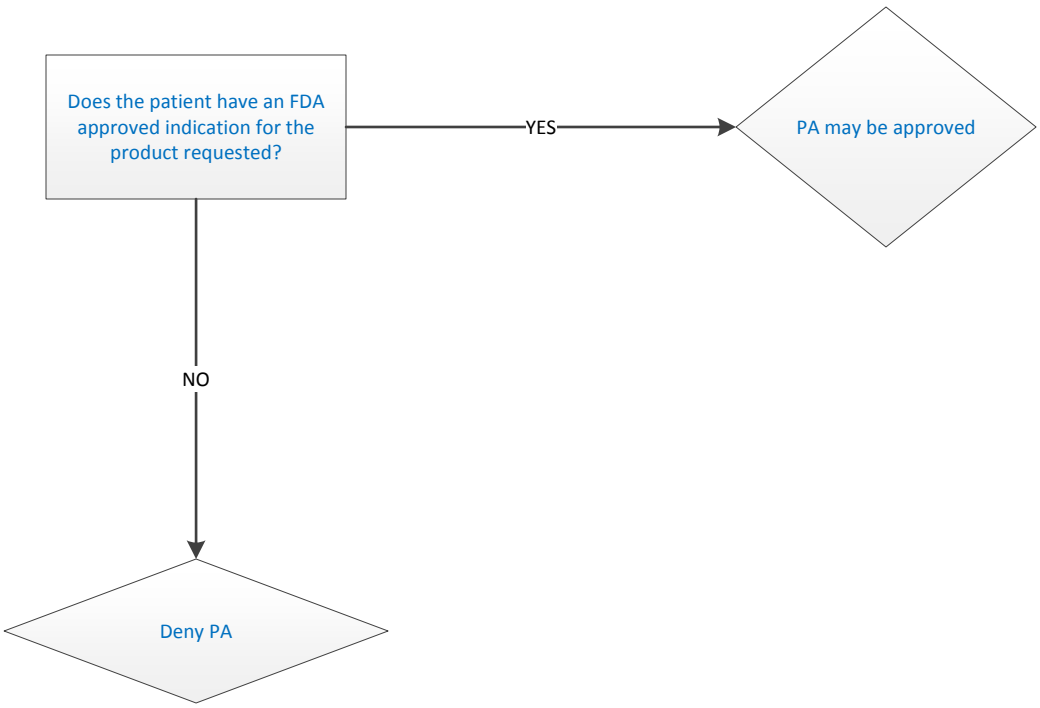
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Immunomodulators Authorization Algorithm



TOPICAL ACNE AGENTS
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 a branded topical acne agent must meet the following criteria:

- **Patients under the age of 10 or older than 35 must have a dermatologist involved in therapy**
- **Requires step therapy. See topical acne agents criteria for more information.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name	Dermatologist Involved in therapy (if patient is <10 and >35): Next Appointment date:		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this Request:**		
LIST ALL FAILED MEDICATIONS AND REASON:			
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature	Date		

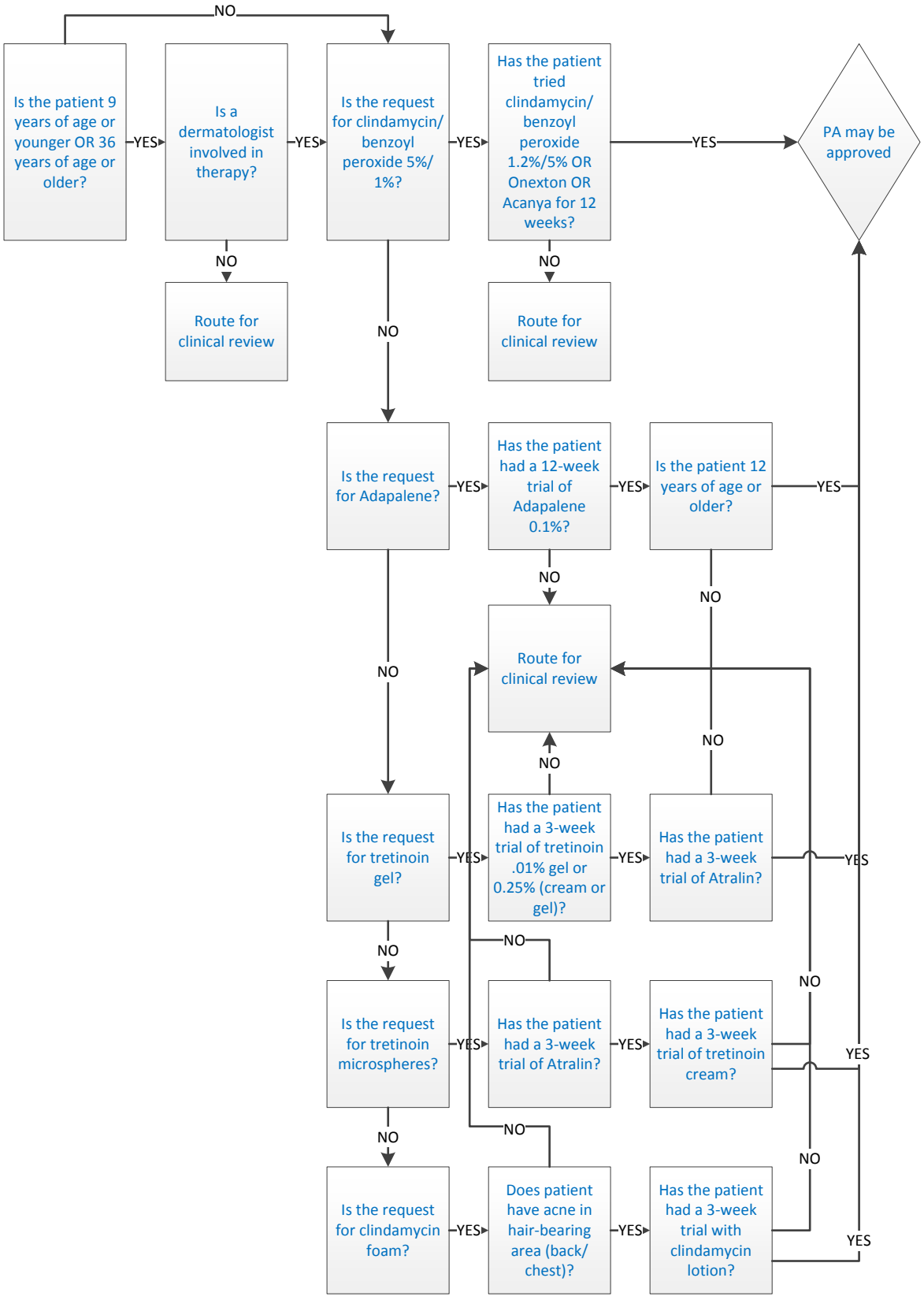
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Topical Acne Agents Authorization Algorithm



LOCAL ANESTHETICS (TOPICAL) PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 a topical local anesthetic must meet the following criteria:

- **These medications will only be covered when prescribed for use prior to certain procedures (e.g., placement of a peripheral or central line or injections through an implanted port). Medical procedure must be listed on PA form.**
- **PA not required for patients 12 years of age and younger.**

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ EMLA □ SYNERA	**Medical Procedure:**		
Prescriber (or Staff) / Pharmacy Signature		Date	

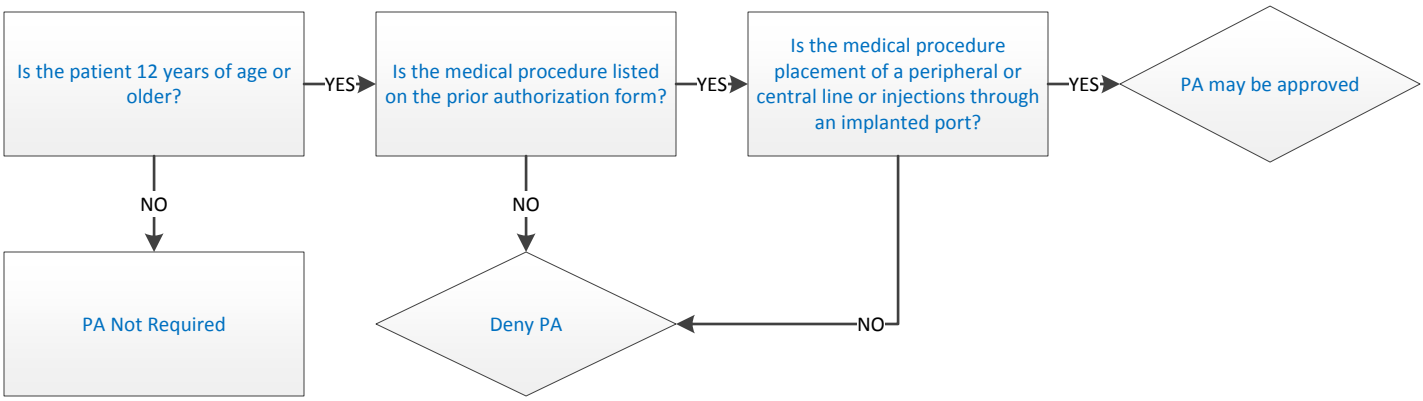
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Topical Anesthetics Authorization Algorithm



health information designs

Prior Authorization Vendor for ND Medicaid

Topical Ketoconazole Products Prior Authorization

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

ND Medicaid requires that patients who are prescribed Extina, Xolegel, and Ketocon Plus must first try a covered ketoconazole medication.

Note:

- ***Ketoconazole creams and ketoconazole shampoos do not require a prior authorization.***

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ **Extina** □ **Xolegel** □ **Ketocon Plus**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Medication Failed _____	Start Date: End Date:	Dose: Frequency:	
Prescriber (or Staff) / Pharmacy Signature		Date	

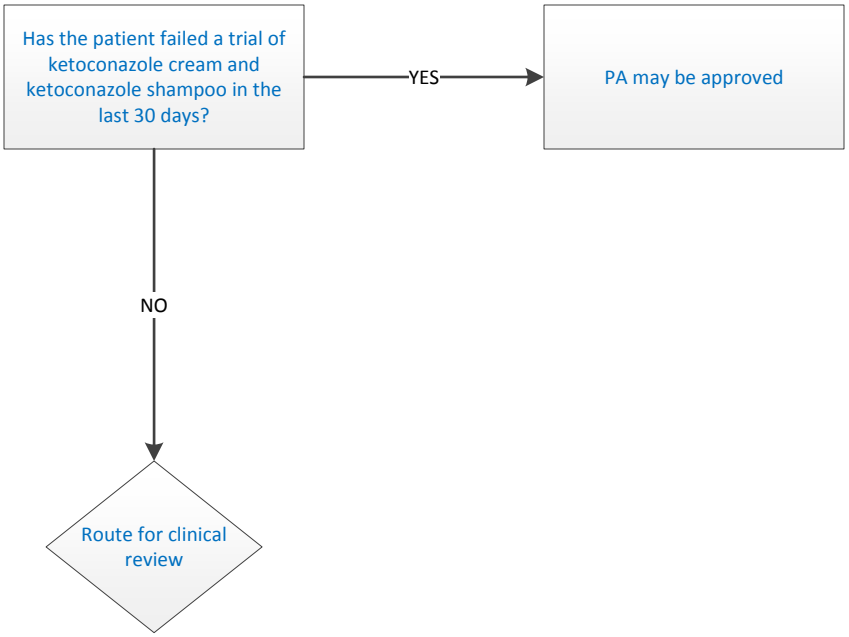
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Topical Ketoconazole Agents Authorization Algorithm



Serotonin (5-HT$_1$) Receptor Agonists - Triptan PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Axert, Frova, Naratriptan, Relpax, Rizatriptan, Treximet, or Zolmitriptan must try Sumatriptan as first line therapy.

***Note:**

- **Sumatriptan does not require a PA.**
- **Injectables are not subject to a prior authorization at this time.**
- **Requires step therapy. See triptan criteria for more information.**

Part I: TO BE COMPLETED BY PRESCRIBER

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:	**Diagnosis for this request:**
□ NARATRIPTAN □ RELPAX □ RIZATRIPTAN □ AXERT □ TREXIMET □ FROVA □ ZOLMITRIPTAN	**Does patient have menstrual migraine?** **Is patient's migraine long in duration and does it recur?**

Qualifications for coverage:

□ Failed sumatriptan therapy	Start Date	End Date	Dose	Frequency
LIST ALL FAILED MEDICATIONS AND REASONS:				

□ *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 recipient.*

Prescriber (or Staff) / Pharmacy Signature	Date

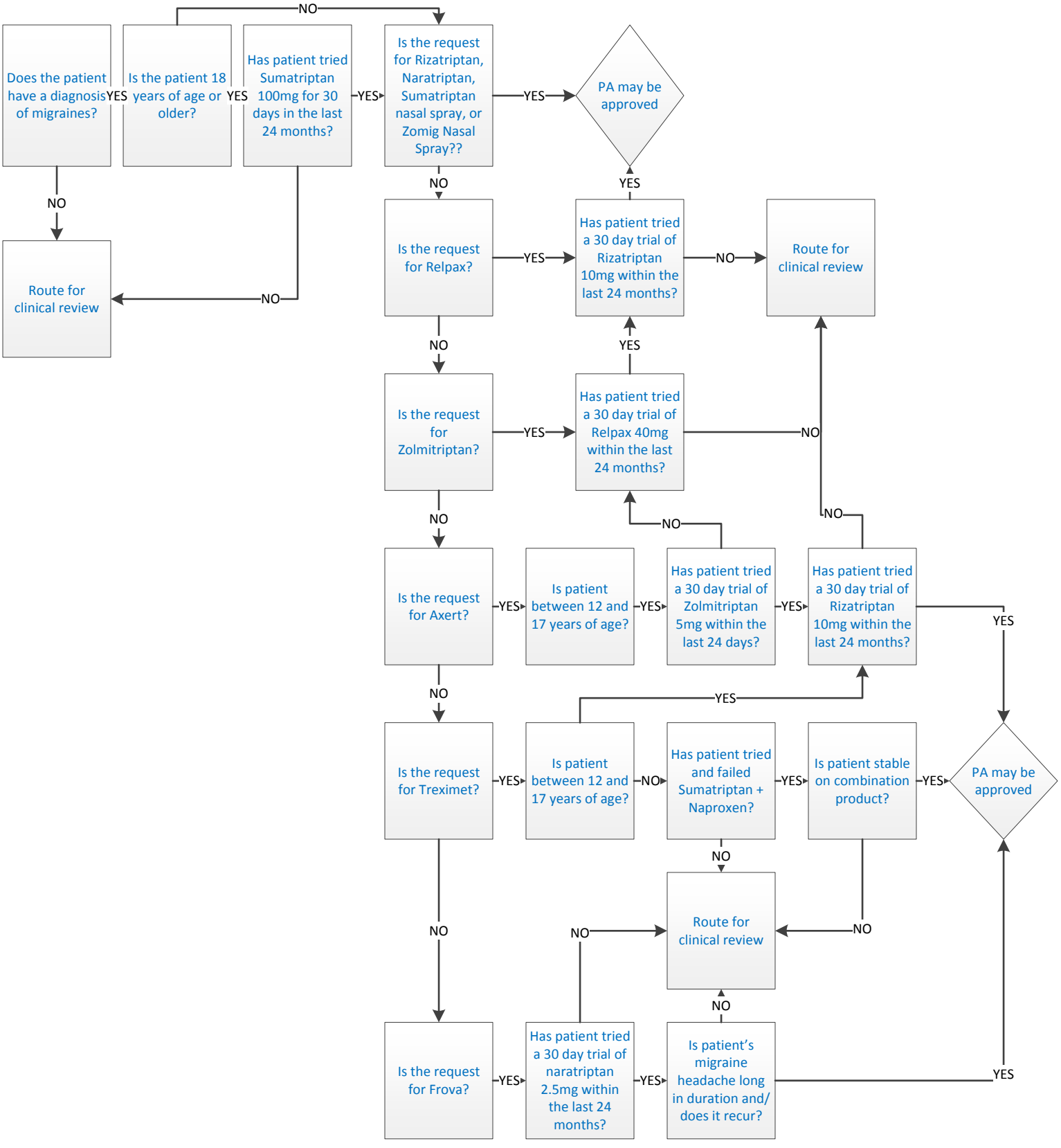
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Triptans Authorization Algorithm



TYSABRI PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Tysabri must meet the following criteria:

- **Patient must have a confirmed diagnosis of multiple sclerosis or Crohn's disease.**
- **Requires step therapy. See Tysabri criteria for more information.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ TYSABRI	**FDA approved indication for this request:**		

• **Has patient experienced a reduction in relapse rate? (renewal requests)**	□ YES	□ NO
• **Has the patient had persistent positive anti-natalizumab antibody titers (2 consecutive positive tests 4 weeks or more apart)**	□ YES	□ NO
• **Is the patient experiencing early aggressive disease? (>=2 relapses in the year and >= 1 Cadolinium (Cd)+ lesion)?**	□ YES	□ NO

List all failed medications:

Prescriber (or Staff) / Pharmacy Signature	Date

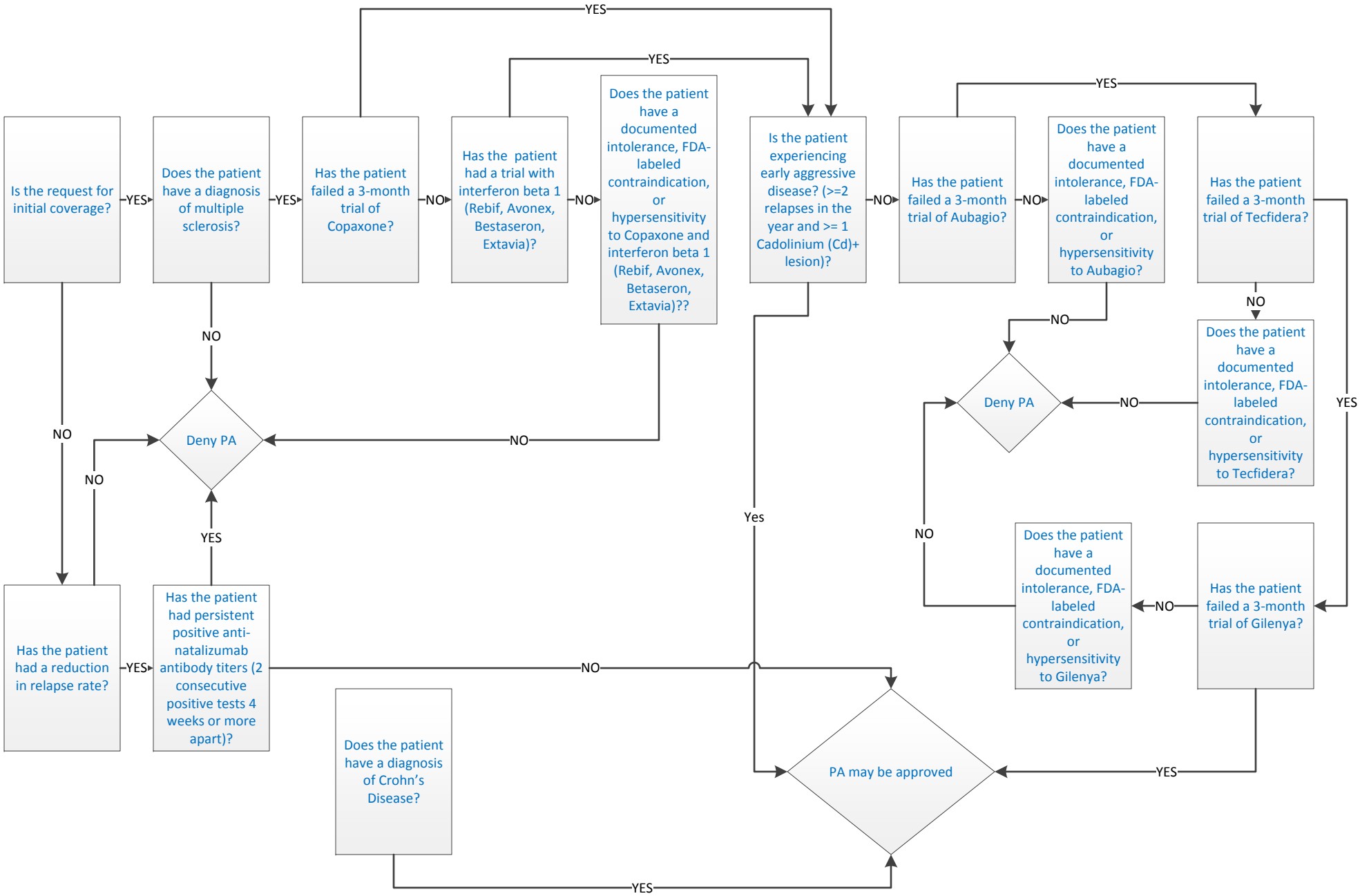
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Tysabri Authorization Algorithm



ULORIC PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Uloric must try allopurinol as first line therapy or have documented renal/hepatic dysfunction.

- Allopurinol does not require a prior authorization.
- Allopurinol doses must be 300 mg or greater to be considered failed therapy.

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ ULORIC	**Diagnosis for this request:**		

Qualifications for coverage:

□ FAILED ALLOPURINOL THERAPY	Start Date	End Date	Dose	Frequency
□ RENAL OR HEPATIC IMPAIRMENT				
□ *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 recipient.*				
Prescriber (or Staff) / Pharmacy Signature			Date	

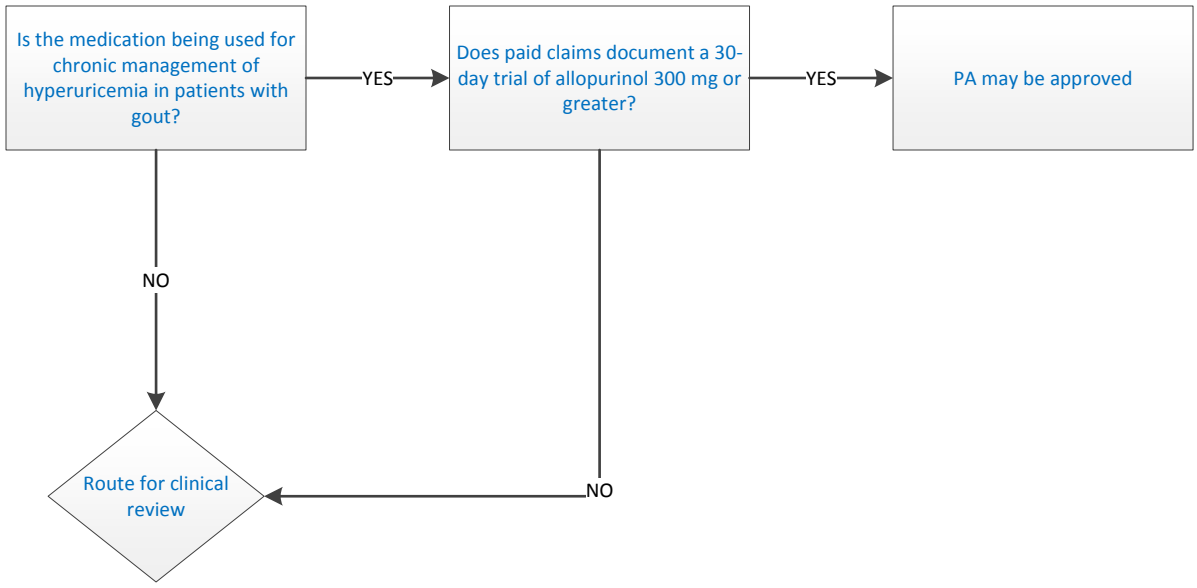
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Uloric Authorization Algorithm



VANOS PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Vanos must meet the following criteria:

- **Patient must be 12 years of age and older.**
- **Patient must have documented failure with a generic topical steroid in the same potency class (Ultravate, Temovate, Diprolene).**

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ VANOS	**Diagnosis for this Request:**		
Failed Therapy (dose and frequency): □	**Start Date:** **End Date:**		
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature		Date	

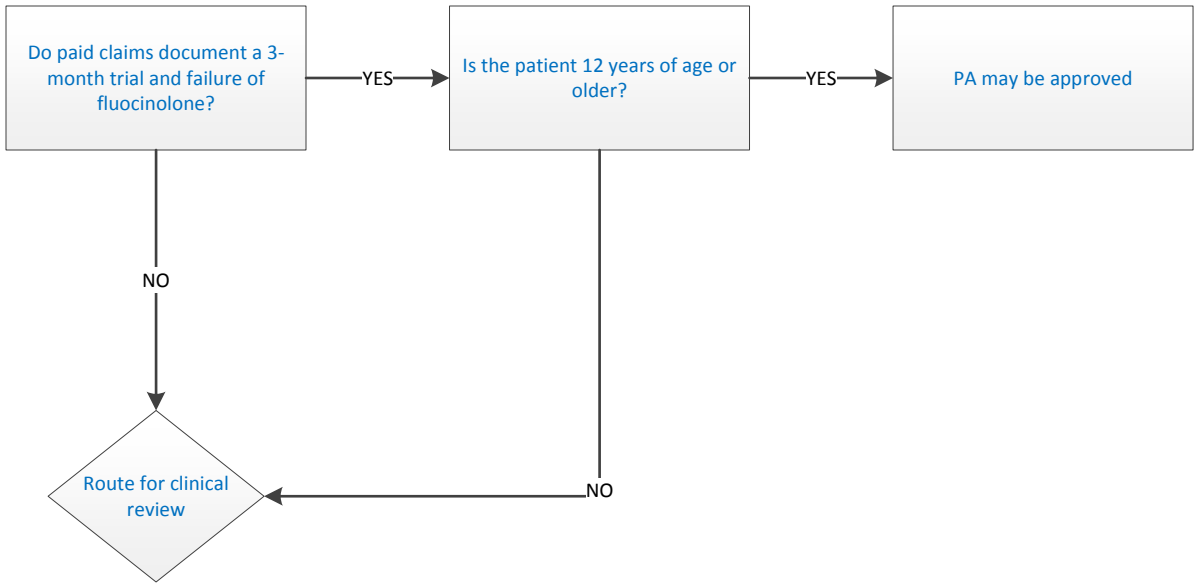
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Vanos Authorization Algorithm



VECAMYL
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Vecamyl must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Patient must have documented history of failure to achieve blood pressure goals (using maximum tolerated doses of all first and second line agents) as defined by the most recent JNC report.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist Involved in Therapy		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ VECAMYL	**Diagnosis for this Request:**		
Failed Therapy:	**Start Date:** **End Date:**		
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature	Date		

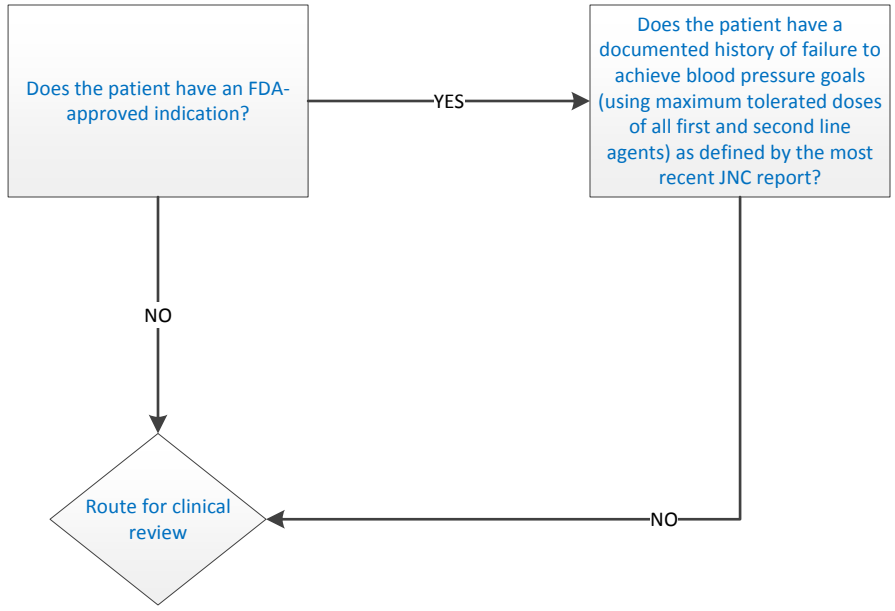
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Vecamyl Authorization Algorithm



VIEKIRA PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Viekira must meet the following criteria:

- Patient must be ≥ 18 years old.
- Must have a diagnosis of genotype 1 chronic hepatitis C virus.
- Liver biopsy showing fibrosis corresponding to a Metavir score of greater than or equal to 2 or Ishak score of greater than or equal to 3 or other accepted test demonstrating liver fibrosis.
- Must be prescribed by or in consultation with a hepatologist, gastroenterologist, or infectious disease specialist.
- Female patients, or partners of male patients, must have a negative pregnancy test within 30 days prior to initiation of therapy and monthly during treatment.
- Documentation showing that patient is drug and alcohol free for the past 12 months
- Viekira is contraindicated in patients with severe hepatic impairment.
- Viekira is contraindicated with the following drug classes: alpha 1-adrenoreceptor antagonist (alfuzosin); anticonvulsants (carbamazepine, phenytoin, phenobarbital); antihyperlipidemic agent (gemfibrozil); antimycobacterial (rifampin); ergot derivatives (ergotamine, dihydroergotamine, ergonovine, methylergonovine); ethinyl estradiol containing products (combined oral contraceptives); herbal products (St. John's wort); HMG-CoA reductase inhibitors (lovastatin, simvastatin); neuroleptics (pimozide); non-nucleoside reverse transcriptase inhibitor (efavirenz); phosphodiesterase-5 inhibitor (sildenafil); sedative/hypnotics (triazolam, orally administered midazolam).

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug □ **Viekira** Dosage _____	**Documented liver fibrosis**	**Diagnosis for this request** **Genotype**	**Patient is drug and alcohol free for past 12 months** □ YES □ NO **Does the female patients, or partner of male patient, have a negative pregnancy test** □ YES □ NO
		Ribavirin dose	

Is the patient post-liver transplant? □ YES □ NO Has the patient been previously treated for chronic hepatitis C? □ YES □ NO If yes, please indicate past treatment regimen(s), dates of treatment, and response to therapy:	Baseline HCV RNA: HCV RNA 4 weeks after starting therapy:
Physician (or Staff) / Pharmacy Signature	Date

Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

Revised: 06/04/2015

Hepatitis C Patient Consent Form

I, _____, have been counseled by my healthcare provider on the following:

- ☐ I agree to complete the entire course of treatment and have laboratory tests before starting, during, and after completing treatment as ordered by my healthcare provider.
- ☐ I understand that for the medication to work, it is important that I take my medication each day for the entire course of treatment.
- ☐ I understand the importance to not drink alcohol or use illicit drugs during and after my treatment for Hepatitis C.
- ☐ I understand how to avoid being re-infected with Hepatitis C during and after my treatment.
- ☐ (Females) I understand that these drugs are harmful to babies. I will use two methods to avoid getting pregnant. I understand that this medication may cause serious birth defects to an unborn child for up to 6 months after I have completed my treatment.
- ☐ (Males) I understand that while I am taking the medication, I must avoid getting my partner pregnant. If my partner becomes pregnant, the baby may have serious birth defects. My partner and I will prevent pregnancy using two forms of birth control for up to 6 months after my treatment is complete. If I have a committed partner, I have discussed these risks with her.

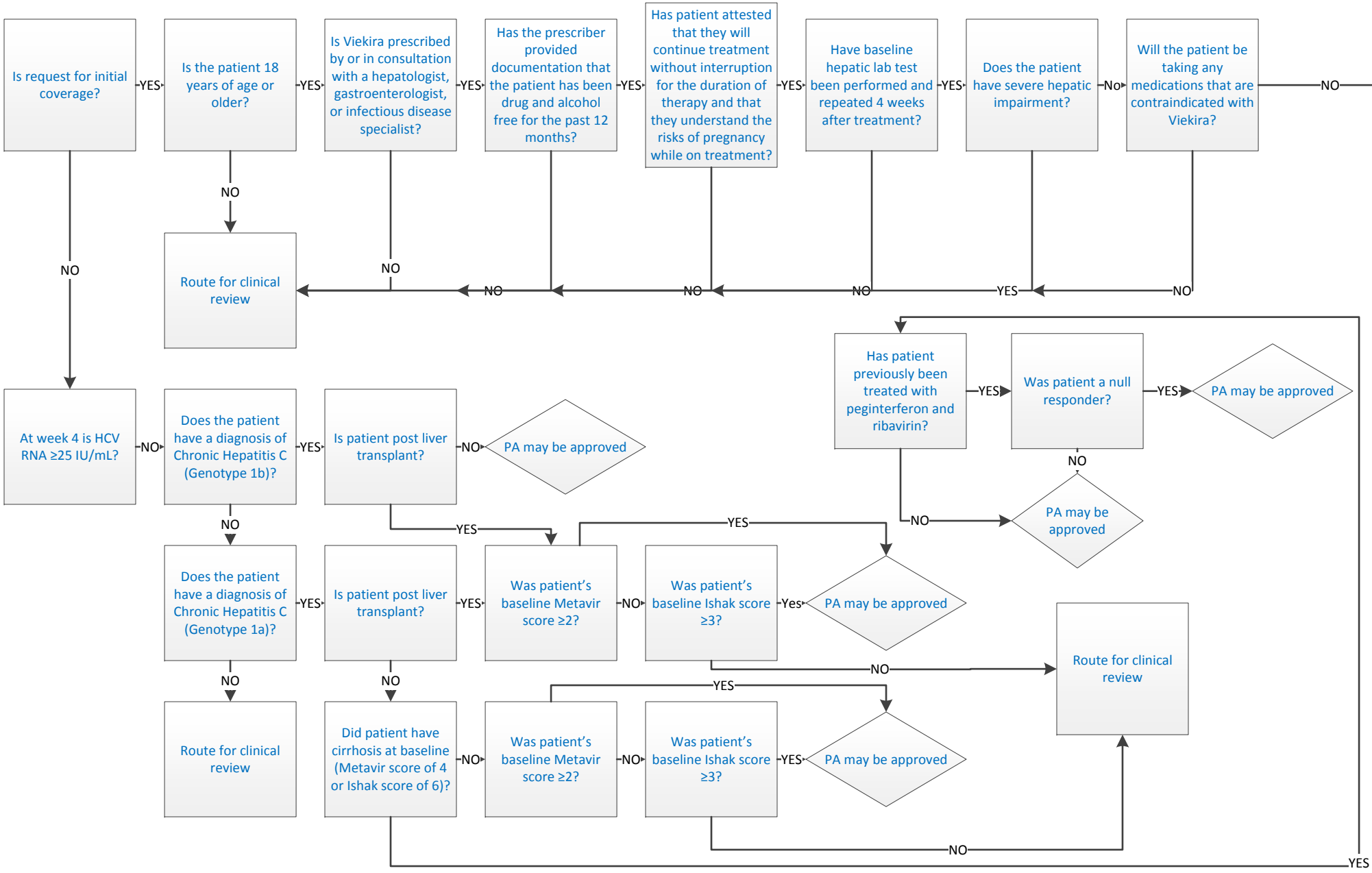
Patient Signature _____ Date __/__/____

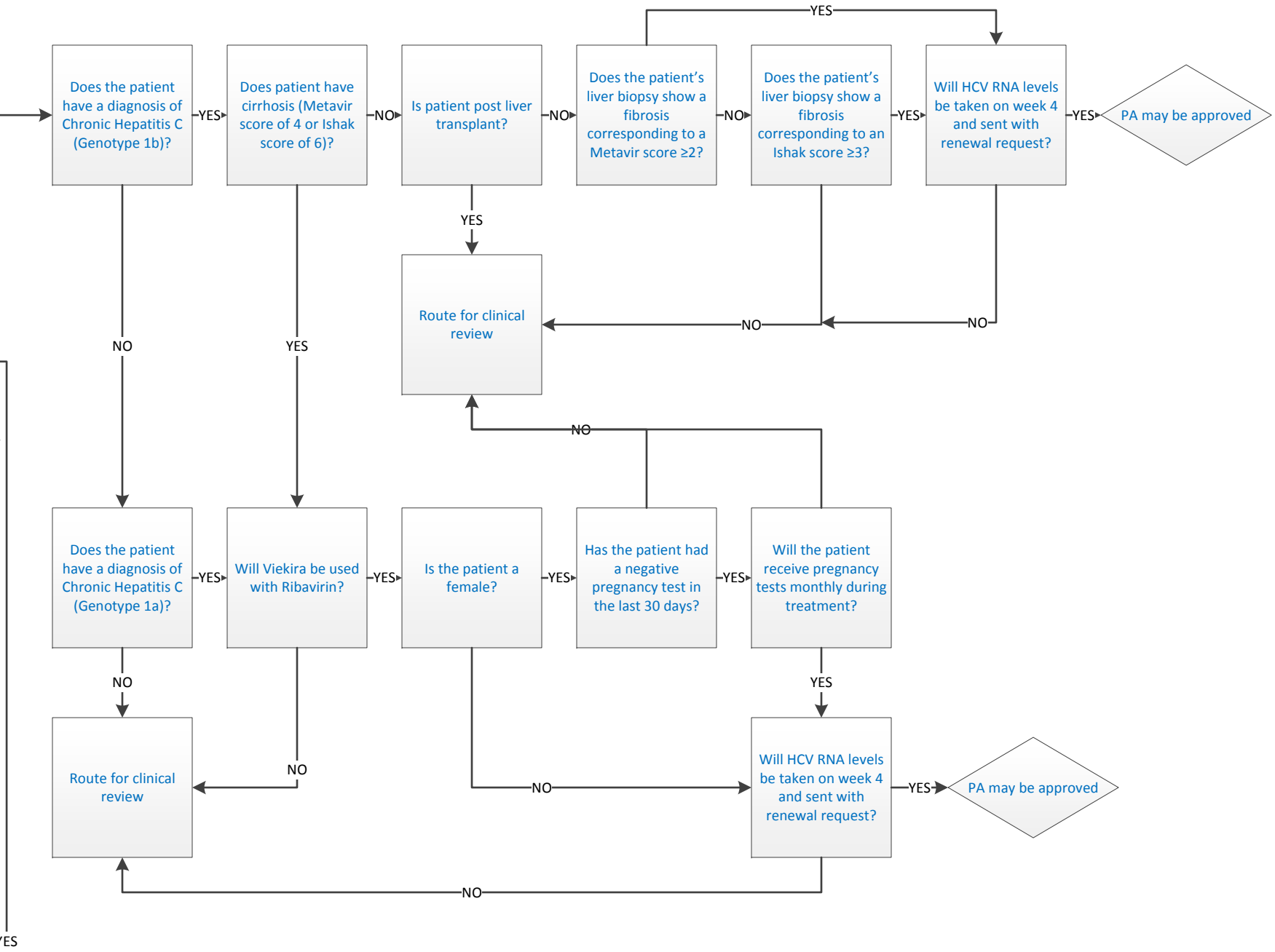
Pharmacy or Prescriber Representative:

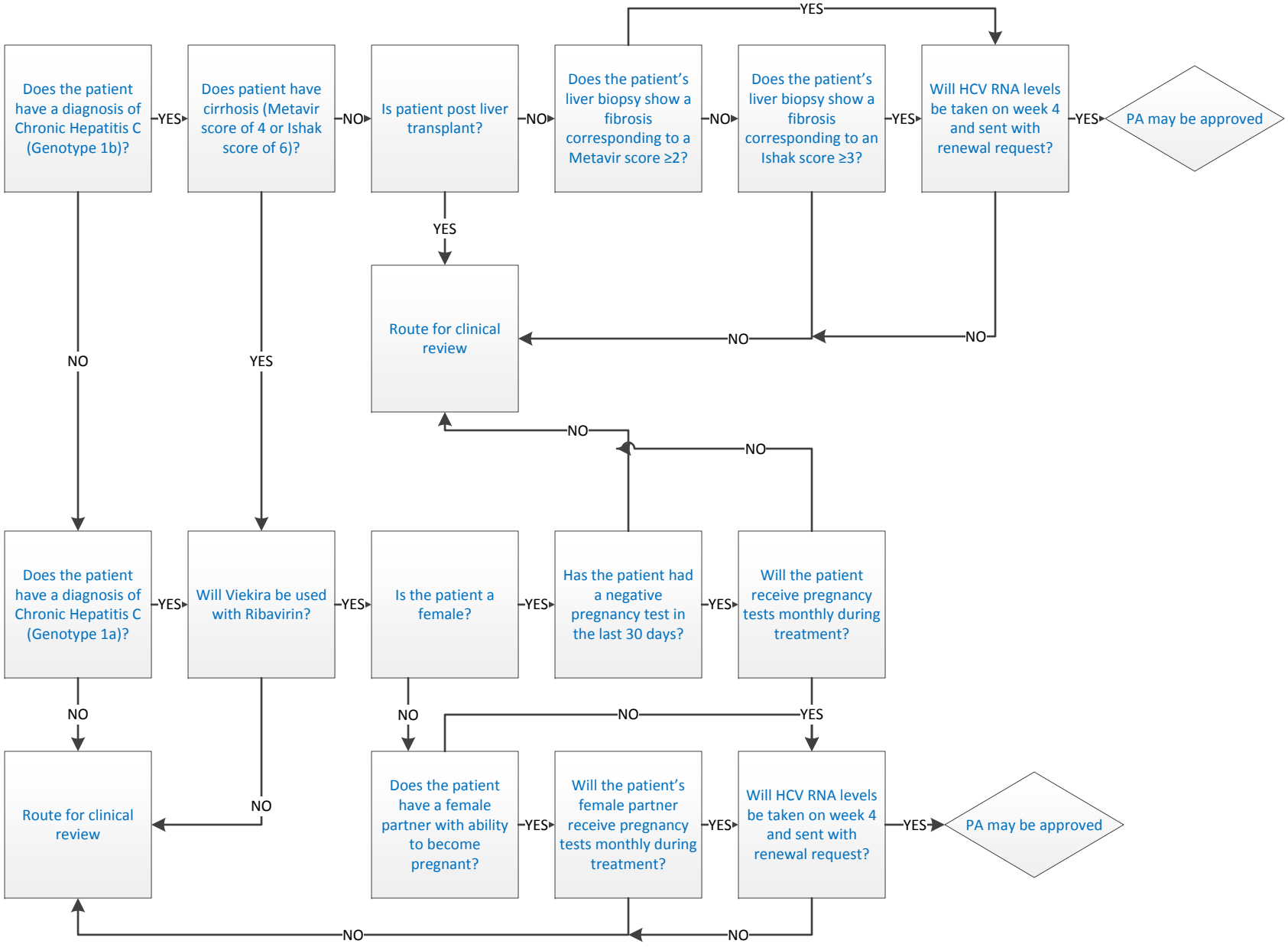
Signature _____ Date __/__/____

By signature, the pharmacy or prescriber representative confirms the contract has been reviewed with the patient.

North Dakota Department of Human Services
Viekira Authorization Algorithm




Does the patient have a diagnosis of Chronic Hepatitis C (Genotype 1b)?
YES
Does patient have cirrhosis (Metavir score of 4 or Ishak score of 6)?
NO
Is patient post liver transplant?
NO
Does the patient's liver biopsy show a fibrosis corresponding to a Metavir score ≥2?
NO
Does the patient's liver biopsy show a fibrosis corresponding to an Ishak score ≥3?
YES
Will HCV RNA levels be taken on week 4 and sent with renewal request?
YES
PA may be approved
YES
NO
YES
Route for clinical review
NO
NO
NO
Does the patient have a diagnosis of Chronic Hepatitis C (Genotype 1a)?
YES
Will Viekira be used with Ribavirin?
YES
Is the patient a female?
YES
Has the patient had a negative pregnancy test in the last 30 days?
YES
Will the patient receive pregnancy tests monthly during treatment?
NO
YES
Route for clinical review
NO
NO
Will HCV RNA levels be taken on week 4 and sent with renewal request?
YES
PA may be approved
NO
YES


Does the patient have a diagnosis of Chronic Hepatitis C (Genotype 1b)?
YES
Does patient have cirrhosis (Metavir score of 4 or Ishak score of 6)?
NO
Is patient post liver transplant?
NO
Does the patient's liver biopsy show a fibrosis corresponding to a Metavir score ≥2?
NO
Does the patient's liver biopsy show a fibrosis corresponding to an Ishak score ≥3?
YES
Will HCV RNA levels be taken on week 4 and sent with renewal request?
YES
PA may be approved
YES
YES
Route for clinical review
NO
NO
NO
NO
NO
YES
Does the patient have a diagnosis of Chronic Hepatitis C (Genotype 1a)?
YES
Will Viekira be used with Ribavirin?
YES
Is the patient a female?
YES
Has the patient had a negative pregnancy test in the last 30 days?
YES
Will the patient receive pregnancy tests monthly during treatment?
NO
NO
NO
YES
Route for clinical review
NO
Does the patient have a female partner with ability to become pregnant?
YES
Will the patient's female partner receive pregnancy tests monthly during treatment?
YES
Will HCV RNA levels be taken on week 4 and sent with renewal request?
YES
PA may be approved
NO
NO

Vusion PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Vusion must try other topical antifungal products as first line therapy.

***Note: Nystatin and clotrimazole do not require a prior authorization.**

Part I: TO BE COMPLETED BY PRESCRIBER

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: □ VUSION	**Diagnosis for this request:**		

Qualifications for coverage:

□ Failed antifungal therapy Name of medication failed: _____	Start Date	End Date	Dose	Frequency

□ *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 recipient.*

Prescriber (or Staff) / Pharmacy Signature	Date

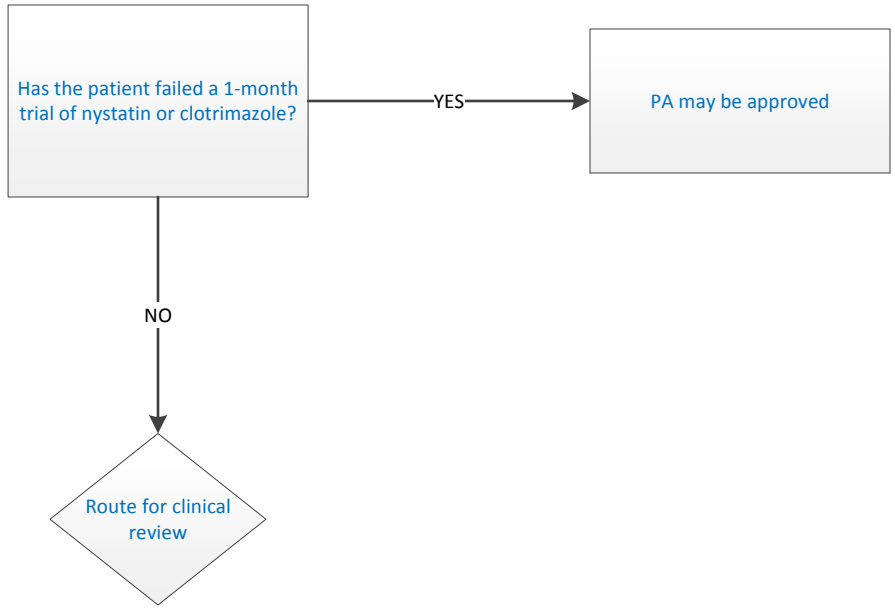
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Vusion Authorization Algorithm



health information designs

Xeljanz
Prior Authorization

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 patients receiving a new prescription for Xeljanz must meet the following criteria:

Note:

- **Patient must have an inadequate response or intolerance to methotrexate.**
- **Patient must have a test for latent tuberculosis prior to starting Xeljanz.**
- **Patient must have current lab monitoring prior to starting Xeljanz (CBC, liver enzymes, lipid panel)**
- **Use with caution in patients that may be at increased risk of gastrointestinal perforations.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

QUALIFICATIONS FOR COVERAGE:

Requested Drug and Dosage: □ **Xeljanz**	Diagnosis for this request:
TB test in the past 6 months □ Yes □ No Lab monitoring has occurred and measurements within acceptable limits (i.e., lymphocytes, neutrophils, hemoglobin, lipids, and liver enzymes) □ Yes □ NO Has or has had active hepatitis B or C virus □ Yes □ NO	Failed methotrexate therapy Start date: End date:
Prescriber (or Staff) / Pharmacy Signature	Date

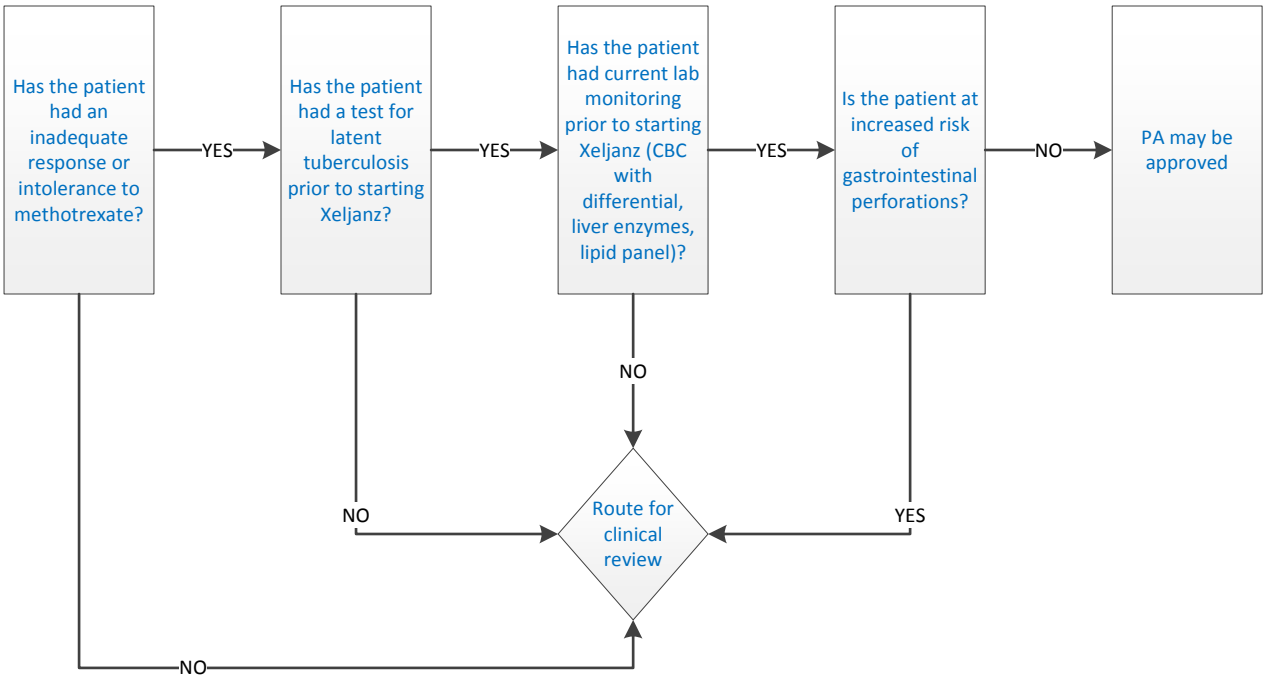
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Xeljanz Authorization Algorithm



health information designs

Prior Authorization Vendor for ND Medicaid

Xenical Prior Authorization

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 Xenical must be seen by a dietician.
Note:

- ***Patient must have dietician evaluation attached to PA form including height and weight.***
- ***BMI must be equal to or greater than 40.***
- ***5% weight loss must be realized for continued approval (every 6 months).***

Part I: TO BE COMPLETED BY PRESCRIBER

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: □ XENICAL	**Diagnosis for this request:**		

Qualifications for coverage:

□ Dietician evaluation attached	Height:	Weight:	BMI:
Prescriber (or Staff) / Pharmacy Signature		Date	

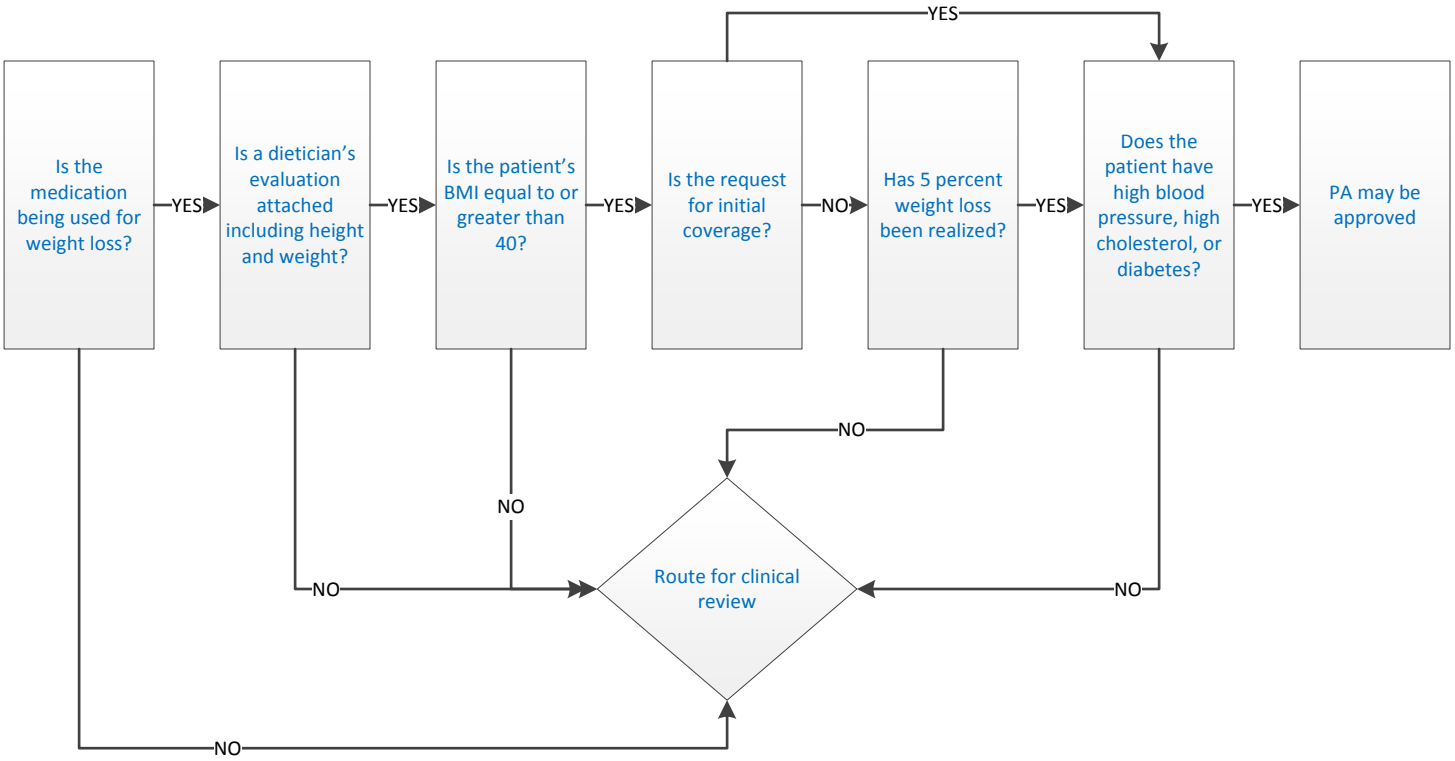
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Xenical Authorization Algorithm



XIFAXAN PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Xifaxan must meet the following guidelines:

- Patient must be 12 years of age or older and have a diagnosis of traveler's diarrhea caused by noninvasive strains of E. coli. Patient must try ciprofloxacin, levofloxacin, OR norfloxacin before PA for Xifaxan will be approved.
- Patient must be 18 years of age or older and have a risk of recurrence of overt hepatic encephalopathy.
- Do not use in patients with diarrhea complicated by fever or blood in the stool or diarrhea due to pathogens other than E. coli.

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ XIFAXAN	**Diagnosis for this Request:** □ TRAVELER'S DIARRHEA: 200 mg three times a day for 3 days □ HEPATIC ENCEPHALOPATHY: 550 mg two times a day		
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature		Date	

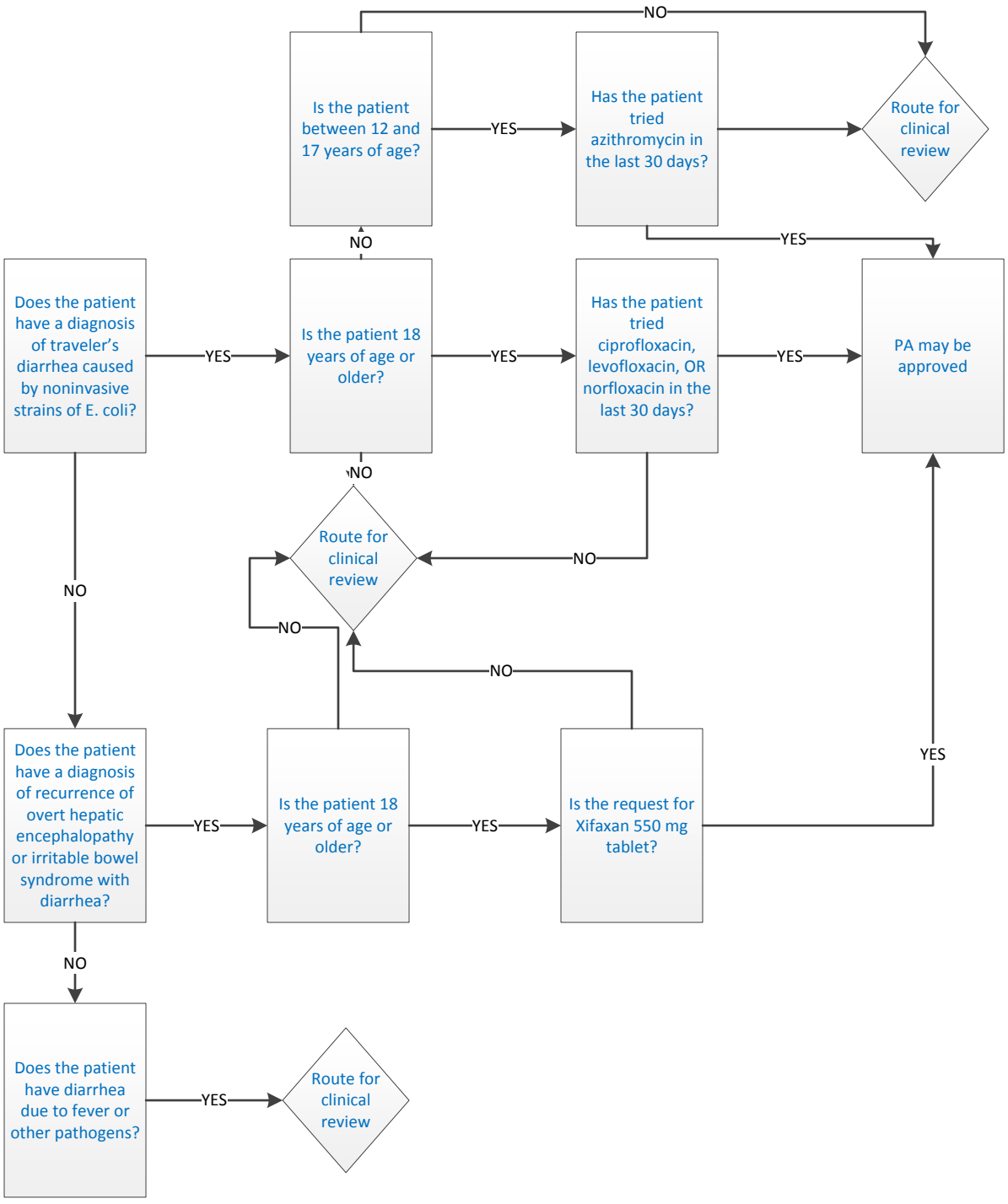
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Xifaxan Authorization Algorithm



XOLAIR PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Xolair must meet the following criteria:

- **Patient must have moderate to severe persistent asthma**
- **Patient must have serum IgE level between 30 and 700 IU/mL**
- **Requires step therapy. See Xolair criteria for more information.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name	Specialist Involved in Therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage: □ XOLAIR	**Diagnosis for this Request:**	**Serum IgE Level:**

Is the patient adequately controlled by an inhaled steroid?
Has the patient had positive skin tests or in vitro reactivity to a perennial aeroallergen?

Patient's weight: _____

List all failed medications and reasons:

Prescriber (or Staff) / Pharmacy Signature	Date

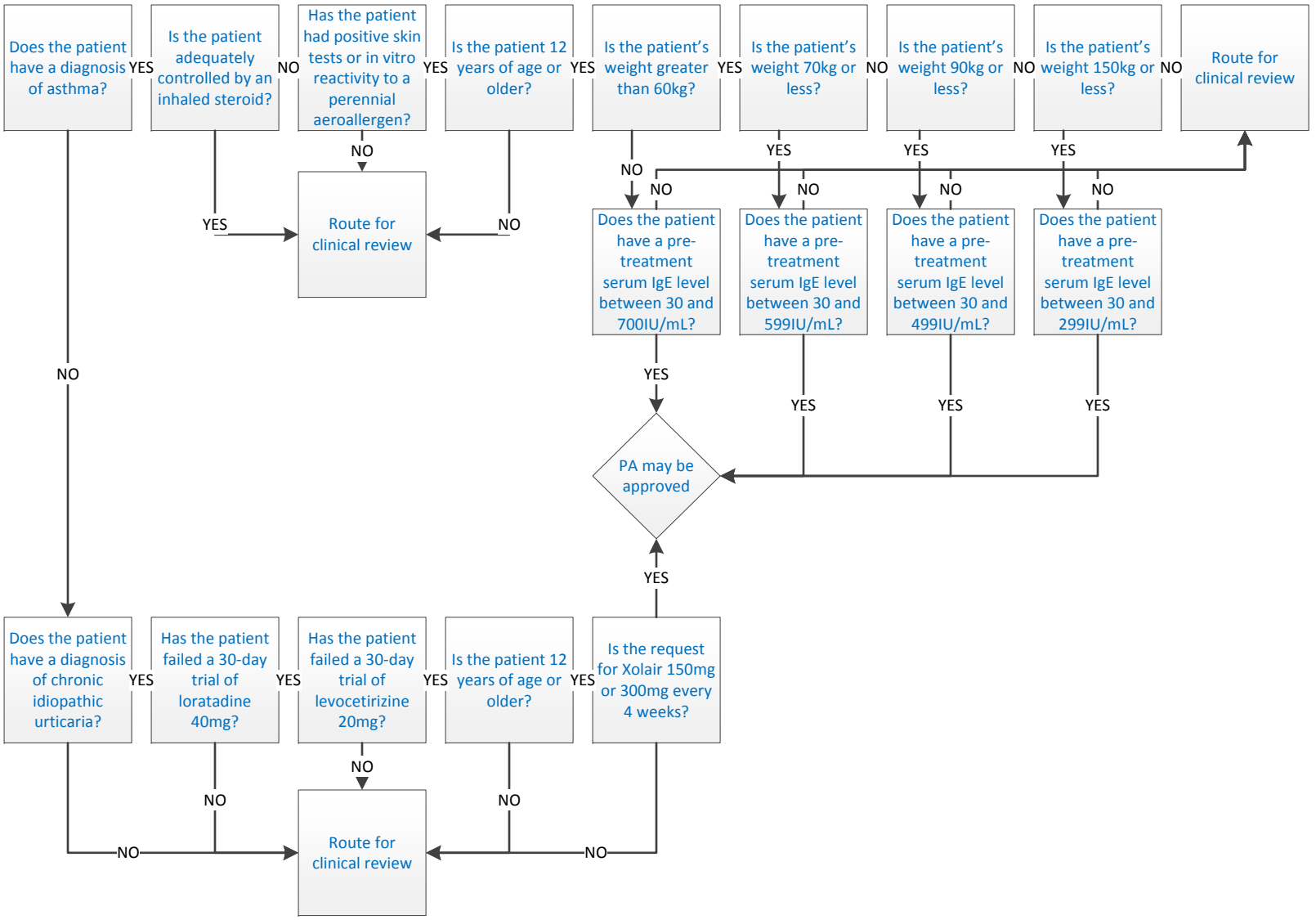
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Xolair Authorization Algorithm



health information designs

Xyrem Prior Authorization

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 patients who are prescribed Xyrem must meet these guidelines:
Note:

- ***Must be 18 years or older.***
- ***Must have a diagnosis of excessive daytime sleepiness and cataplexy in patients with narcolepsy.***
- ***Must be enrolled in the Xyrem REMS Program***

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ **Xyrem**	**Diagnosis for this request:**	**List failed medication:**	
Qualifications for coverage:			
□ Enrolled in Xyrem REMS Program	Enrolled Date:	Dose:	
Is patient taking any sedative/hypnotics, opioids, or muscle relaxants?		□ YES □ NO	
Prescriber (or Staff) / Pharmacy Signature		Date	

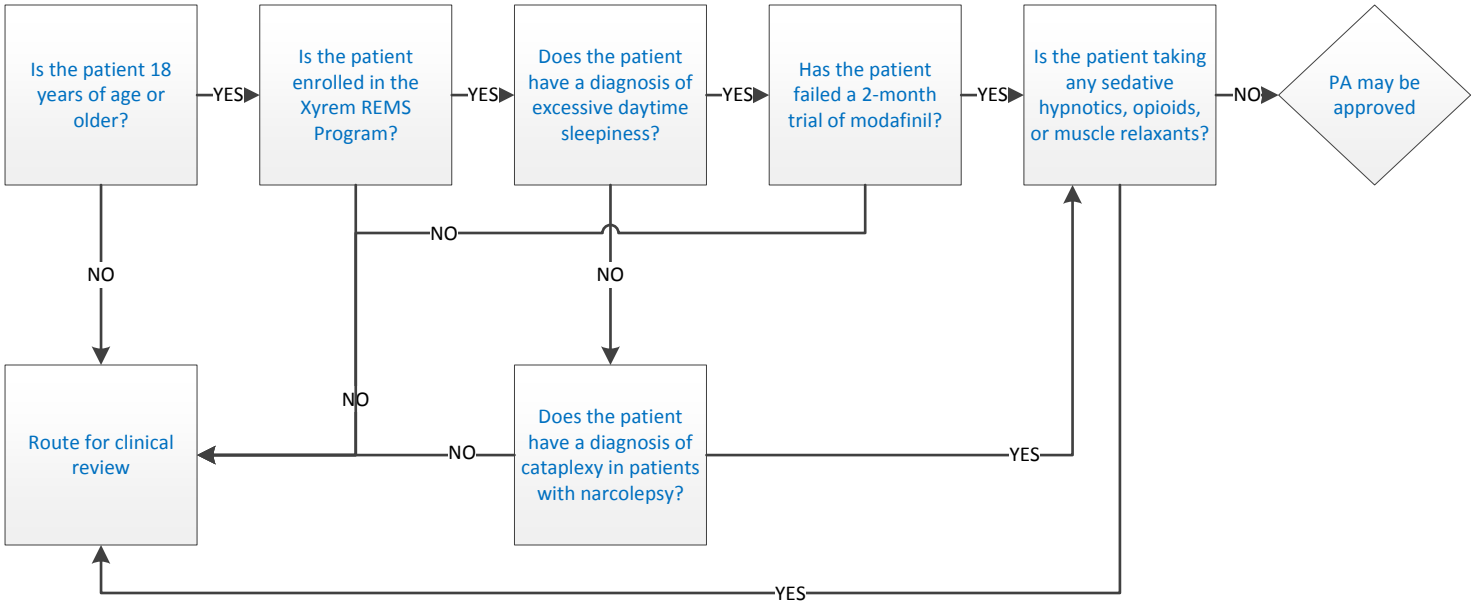
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME (REQUIRED)			ND MEDICAID PROVIDER NUMBER (REQUIRED)
PHONE NUMBER	FAX NUMBER	DRUG	NDC # (REQUIRED)

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Xyrem Authorization Algorithm



health information designs

Prior Authorization Vendor for ND Medicaid

Zanaflex Capsule PA Form

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

ND Medicaid requires that patients receiving Zanaflex capsules must use tizanidine tablets first line.
Note:

- **Tizanidine tablets do not require a PA.**
- **Patient must fail therapy on tizanidine tablets before a PA may be granted.**

Part I: TO BE COMPLETED BY PRESCRIBER

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:	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Failed generic drug	Start Date: End Date:	Dose: Frequency:	
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature		Date	

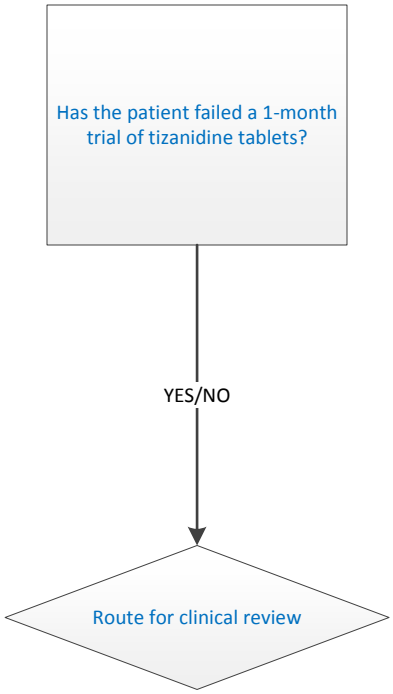
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Zanaflex Capsule Authorization Algorithm



ZONTIVITY
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

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 Zontivity must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Patient must be 18 years of age or older.**
- **Use with aspirin and/or clopidogrel (limited clinical experience with Zontivity as the only antiplatelet agent).**
- **Contraindicated in patients with a history of stroke, transient ischemic attack, or intracranial hemorrhage.**

Part I: TO BE COMPLETED BY PHYSICIAN

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: □ ZONTIVITY	**Diagnosis for this Request:**		
Using in combination with: □ ASA □ ASA/CLOPIDOGREL □ CLOPIDOGREL			
□ *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 recipient.*			
Prescriber (or Staff) / Pharmacy Signature	Date		

Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Zontivity Authorization Algorithm