# DUR Board Meeting
# December 3, 2014
# Pioneer Room
# State Capitol

north dakota
department of
human services

**North Dakota Medicaid**
**DUR Board Meeting Agenda**
**Pioneer Room**
**State Capitol**
**600 East Blvd. Avenue**
**Bismarck, ND**
**December 3, 2014**
**1pm**

1. Administrative items
    - Travel vouchers
    - Introduction of new members

2. Old business

| | |
|---|---|
| • Review and approval of minutes of 09/14 meeting | Chair |
| • Budget update | Brendan |
| • Update on Synagis | Brendan |
| • Update on benzodiazepine utilization | Brendan |
| • Second review of testosterone products | Brendan |
| • Second review of phosphate binders | Brendan |
| • Second review of Zontivity | Brendan |
| • Second review of Evzio | Brendan |

3. New business

| | |
|---|---|
| • Annual PA review | HID |
| • Criteria recommendations | HID |
| • Upcoming meeting date/agenda | Chair |

4. Adjourn — Chair

**Please remember to silence all cellular phones during the meeting.**

**Drug Utilization Review (DUR) Meeting Minutes**
**September 3, 2014**

**Members Present:** John Savageau, Jeffrey Hostetter, Peter Woodrow, Russ Sobotta, Tanya Schmidt, Steve Irsfeld, Michael Booth, Carlotta McCleary, Laura Schield, Katie Kram, Wendy Brown, Emmet Kenney

**Members Absent**: Todd Twogood, James Carlson, Leann Ness

**Medicaid Pharmacy Department:** Brendan Joyce, Gary Betting

J. Savageau called the meeting to order at 1:00 p.m. Chair J. Savageau asked for a motion to approve the minutes from the June meeting. M. Booth moved that the minutes be approved, and P. Woodrow seconded the motion. Chair J. Savageau called for a voice vote to approve the minutes. The motion passed with no audible dissent.

**Budget update**
B. Joyce distributed and discussed a table showing drug rebate amounts from 1st quarter 2010 through 4th quarter 2013. Approximately 8-9 million dollars are paid out to pharmacies each quarter. Approximately 4-4.5 million dollars are recouped from drug rebates.

**Northera second review**
A motion and second were made at the June meeting to place Northera on prior authorization. The topic was brought up for a second review. There was no public comment. After discussion, Chair J. Savageau called for a voice vote to approve the motion. The motion passed with no audible dissent.

**Oral allergen extracts second review**
A motion and second were made at the June meeting to place oral allergen extracts on prior authorization. The topic was brought up for a second review. There was no public comment. After discussion, Chair J. Savageau called for a voice vote to approve the motion. The motion passed with no audible dissent.

**Updated AAP guidelines for palivizumab prophylaxis**
B. Joyce discussed the updated guidelines for palivizumab (Synagis). The updated guidelines were incorporated into a prior authorization form for the board to review. L. Willshaw, representing MedImmune, spoke regarding Synagis. A motion was made by K. Kram to accept the changes to the current Synagis form to reflect the updated AAP guidelines. W. Brown seconded the motion. Chair J. Savageau called for a voice vote to approve the motion. The motion passed with no audible dissent. The board asked that data be brought back to the December meeting showing how many children during the 2013-2014 Synagis season would not have received medication based on the new guidelines. The board also asked for RSV hospitalization information from the 2013-2014 season, if available. B. Joyce stated that hospitalization data would be virtually impossible to obtain because the diagnosis is not always used for billing purposes.

**NDQuits protocol update**
B. Joyce informed the board of changes in how the recipients receive the form with the updated protocol. Currently, ND Medicaid members who wish to use tobacco cessation medications are required to enroll in phone counseling provided by NDQuits. The new proposed process will allow coverage for medications when participating in face to face or group counseling, which will encourage more successful quit attempts.

**Hepatitis C treatment and compliance**
B. Joyce reviewed current treatment guidelines as well as utilization data for Sovaldi and Olysio. Board members reviewed prior authorization forms for Sovaldi and Olysio. The department would like guidance from the board on criteria for approval as well as long-term oversight to ensure compliance. The board made a recommendation that to demonstrate drug and alcohol free for the past 12 months that all PA requests would be accompanied by 12 months of urine screens.

**Benzodiazepine review**
B. Joyce reviewed benzodiazepine utilization with the board. Data regarding duplicate therapy of benzodiazepines was also discussed. The board asked that more information be provided at the December meeting including ages of recipients, prescribers, and diagnoses.

**Transdermal androgen review**
B. Joyce reviewed transdermal androgen information with the board. Mike Gonzales, representing Abbvie, spoke regarding Androgel. P. Woodrow made a motion to place transdermal androgens on prior authorization. J. Hostetter seconded the motion. This topic will be reviewed at the next meeting.

**Phosphate binders review**
B. Joyce reviewed phosphate binder information with the board. There was no public comment. M. Booth made a motion to place Velphoro on prior authorization. P. Woodrow seconded the motion. This topic will be reviewed at the next meeting.

**Zontivity Review**
B. Joyce reviewed Zontivity information with the board. There was no public comment. W. Brown made a motion to place Zontivity on prior authorization. P. Woodrow seconded the motion. This topic will be reviewed at the next meeting.

**Evzio Review**
B. Joyce reviewed Evzio information with the board. There was no public comment. J. Hostetter made a motion to place Evzio on prior authorization. L. Schield seconded the motion. This topic will be reviewed at the next meeting.

**Criteria Recommendations**
The recommended RDUR criteria enclosed in the packet were developed from product information provided by the manufacturers and usually are 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. P. Woodrow moved to approve the new criteria and M. Booth seconded the motion. Chair J. Savageau called for a voice vote. The motion passed with no audible dissent.

The next DUR board meeting will be held December 3, in Bismarck. J. Hostetter made a motion to adjourn the meeting. P. Woodrow seconded. The motion passed with no audible dissent. J. Savageau adjourned the meeting.

## Synagis Overview (2004 – 2014)

| RSV Season | Amt Paid | # of Doses | Cost of Synagis | # of Patients Treated | # of PA's Approved | Total Costs | Preemies | # </= 2 |
|---|---|---|---|---|---|---|---|---|
| 2004-2005 | $219,058.35 | 314 | $ 332,411.82 | 61 | - | $ 551,470.17 | 75 | 9958 |
| 2005-2006 | $378,547.65 | 305 | $ 376,323.11 | 63 | - | $ 754,870.76 | 78 | 10301 |
| 2006-2007 | $168,277.25 | 457 | $ 551,636.87 | 98 | - | $ 719,914.12 | 71 | 10412 |
| 2007-2008 | $356,790.93 | 351 | $ 480,680.57 | 76 | - | $ 837,471.50 | 87 | 11014 |
| 2008-2009 | $245,849.75 | 339 | $ 475,015.41 | 73 | - | $ 720,865.16 | 79 | 11797 |
| 2009-2010 | $535,789.44 | 170 | $ 264,035.47 | 54 | 87 | $ 799,824.91 | 93 | 12665 |
| 2010-2011 | $581,963.75 | 227 | $ 405,387.46 | 67 | 99 | $ 987,351.21 | 78 | 12937 |
| 2011-2012 | $699,033.05 | 211 | $ 382,138.46 | 65 | 117 | $1,081,171.51 | 97 | 13025 |
| 2012-2013 | $798,530.85 | 188 | $ 376,351.47 | 60 | 92 | $1,174,882.32 | 90 | 12963 |
| 2013-2014 | $510,168.26 | 164 | $ 333,557.31 | 61 | 114 | $ 843,725.57 | 55 | 13259 |

| RSV Season | Count of Premature Babies | Overall Recipient Count ≤ 2 |
|---|---|---|
| 2004-2005 | 75 | 9,958 |
| 2005-2006 | 78 | 10,301 |
| 2006-2007 | 71 | 10,412 |
| 2007-2008 | 87 | 11,014 |
| 2008-2009 | 79 | 11,797 |
| 2009-2010 | 93 | 12,665 |
| 2010-2011 | 78 | 12,937 |
| 2011-2012 | 97 | 13,025 |
| 2012-2013 | 90 | 12,963 |
| 2013-2014 | 55* | 13,259 |

*providers may still bill for premature babies for this time period

## Synagis Data – 2013/2014 season

| | |
|---|---|
| **138 total IDs (114 PA approvals and 24 billed medical with no PA)** | |
| **114 PAs approved** | |
| 61 billed on pharmacy side | |
| 83 billed on medical side | |
| **OVERALL PICTURE (114 PA approvals)** | |
| 51 do not meet guidelines | 45% |
| 51 meet guidelines | 45% |
| 12 TPL | |
| **Breakdown of those that do not meet 2014 AAP guidelines** | |
| 29-31/6 | 18 |
| 32-34/6 | 33 |
| **Breakdown of those that meet 2014 AAP guidelines** | |
| Pulmonary abnormalities | 1 |
| CLD | 12 |
| CHD | 5 |
| <29 | 33 |

# Participants in Updated Guidance

- Bronchiolitis Guidelines Committee
- Committee on Infectious Diseases
- 21 Committees, Councils, Sections & Advisory Groups within the AAP
- Outside Groups
  - American Academy of Family physicians
  - American College of Chest Physicians
  - American College of Emergency Physicians
  - American Thoracic Society
  - Emergency Nurses Association
  - Society of Hospital Medicine

# Need for Updated Guidance

- Data on seasonality of RSV circulation
- Data showing risk of RSV hospitalization by gestational age
- Data regarding palivizumab pharmacokinetics
- Data showing a decline in incidence of bronchiolitis hospitalizations
- Data showing no difference in RSV hospitalization rates or RSV attack rates between African-American and white children <24 m of age
- Data showing mortality rates among children hospitalized with RSV are lower than previously estimated
- Data showing a statistically significant but clinically limited episodes of wheezing
- Reports indicating little benefit from prophylaxis among children with Down syndrome and cystic fibrosis
- Reports describing palivizumab resistant RSV isolates among children hospitalized with breakthrough infection
- Independently conducted cost-analyses demonstrating high cost versus limited benefit
- Need to simplify guidance

PEDIATRICS®
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

**Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection**

COMMITTEE ON INFECTIOUS DISEASES AND BRONCHIOLITIS GUIDELINES COMMITTEE

*Pediatrics*; originally published online July 28, 2014;
DOI: 10.1542/peds.2014-1665

The online version of this article, along with updated information and services, is located on the World Wide Web at:
**http://pediatrics.aappublications.org/content/early/2014/07/23/peds.2014-1665**

PEDIATRICS is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1948. PEDIATRICS is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2014 by the American Academy of Pediatrics. All rights reserved. Print ISSN: 0031-4005. Online ISSN: 1098-4275.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

FROM THE AMERICAN ACADEMY OF PEDIATRICS

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

POLICY STATEMENT

# Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection

COMMITTEE ON INFECTIOUS DISEASES AND BRONCHIOLITIS GUIDELINES COMMITTEE

**KEY WORDS**

RSV, respiratory syncytial virus, palivizumab, bronchiolitis, infants and young children, chronic lung disease, congenital heart disease

**ABBREVIATIONS**

AAP—American Academy of Pediatrics
CHD—congenital heart disease
CLD—chronic lung disease
COID—Committee on Infectious Diseases
RSV—respiratory syncytial virus

This document is copyrighted and is property of the American Academy of Pediatrics and its Board of Directors. All authors have filed conflict of interest statements with the American Academy of Pediatrics. Any conflicts have been resolved through a process approved by the Board of Directors. The American Academy of Pediatrics has neither solicited nor accepted any commercial involvement in the development of the content of this publication.

Policy statements from the American Academy of Pediatrics benefit from expertise and resources of liaisons and internal (AAP) and external reviewers. However, policy statements from the American Academy of Pediatrics may not reflect the views of the liaisons or the organizations or government agencies that they represent.

The guidance in this statement does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

*(Continued on last page)*

## abstract

FREE

Palivizumab was licensed in June 1998 by the Food and Drug Administration for the reduction of serious lower respiratory tract infection caused by respiratory syncytial virus (RSV) in children at increased risk of severe disease. Since that time, the American Academy of Pediatrics has updated its guidance for the use of palivizumab 4 times as additional data became available to provide a better understanding of infants and young children at greatest risk of hospitalization attributable to RSV infection. The updated recommendations in this policy statement reflect new information regarding the seasonality of RSV circulation, palivizumab pharmacokinetics, the changing incidence of bronchiolitis hospitalizations, the effect of gestational age and other risk factors on RSV hospitalization rates, the mortality of children hospitalized with RSV infection, the effect of prophylaxis on wheezing, and palivizumab-resistant RSV isolates. This policy statement updates and replaces the recommendations found in the 2012 *Red Book*. *Pediatrics* 2014;134:415–420

Policy statements from the American Academy of Pediatrics (AAP) are designed to provide updated guidance for child health care topics, with an emphasis on evidence-based recommendations whenever possible. Policy statements are reviewed at least every 3 years and updated when appropriate. In following this procedure, the AAP Committee on Infectious Diseases (COID) has undertaken a systematic review of all recent and older peer-reviewed literature relating to the burden of respiratory syncytial virus (RSV) disease in infants and children, focusing on publications that delineate children at greatest risk of serious RSV disease and studies that define pharmacokinetics, safety, and efficacy. Detailed input regarding this guidance has been solicited from 21 committees, councils, sections, and advisory groups within the AAP, as well as organizations outside the AAP. Outside groups include the American College of Chest Physicians, American College of Emergency Physicians, American Thoracic Society, Emergency Nurses Association, National Association of Neonatal Nurses, National Association of Neonatal Nurse Practitioners, and Society of Hospital


Prepared by Health Information Designs, LLC

Medicine. In addition, this review includes all data presented to the COID by the manufacturer of palivizumab.

As part of this deliberative review of palivizumab use, the COID judged the quality of the available data, as well as the impact of palivizumab prophylaxis to reach a unanimous consensus on guidance for the use of palivizumab in the United States. Cost was considered during deliberations by the COID and Bronchiolitis Guideline Committee, but the final guidance as presented here is driven by the limited clinical benefit derived from palivizumab prophylaxis.[1–3]

As detailed in the accompanying technical report,[4] the benefit resulting from this drug is limited. Palivizumab prophylaxis has limited effect on RSV hospitalizations on a population basis, no measurable effect on mortality, and a minimal effect on subsequent wheezing.

This policy statement updates and replaces the most recent AAP recommendations for the use of palivizumab prophylaxis published in 2012 in the 29th edition of the *Red Book*.[5] This policy statement offers specific guidance for the use of palivizumab on the basis of available evidence, as well as expert opinion. A detailed discussion of the foundation of the updated guidance for each category as well as the references for each section may be found in the accompanying technical report,[4] and AAP guidelines for the diagnosis and management of bronchiolitis, which were published in 2006[6] (for which a revision is forthcoming).

The palivizumab package insert states: "Synagis is indicated for the prevention of serious lower respiratory tract disease caused by RSV in children at high risk of RSV disease."[7] In the absence of a specific definition of "high risk" by the US Food and Drug Administration, the AAP has endeavored to provide pediatricians and other health care providers with more precise guidance for determining who is at increased risk since palivizumab was first licensed.[5,8–11]

The informed opinion of the COID and the Bronchiolitis Guidelines Committee, as well as others participating in the current statement, is that palivizumab use should be restricted to the populations detailed below.

## PRETERM INFANTS WITHOUT CHRONIC LUNG DISEASE OF PREMATURITY OR CONGENITAL HEART DISEASE

Palivizumab prophylaxis may be administered to infants born before 29 weeks, 0 days' gestation who are younger than 12 months at the start of the RSV season. For infants born during the RSV season, fewer than 5 monthly doses will be needed.

Available data for infants born at 29 weeks, 0 days' gestation or later do not identify a clear gestational age cutoff for which the benefits of prophylaxis are clear. For this reason, infants born at 29 weeks, 0 days' gestation or later are not universally recommended to receive palivizumab prophylaxis. Infants 29 weeks, 0 days' gestation or later may qualify to receive prophylaxis on the basis of congenital heart disease (CHD), chronic lung disease (CLD), or another condition.

Palivizumab prophylaxis is not recommended in the second year of life on the basis of a history of prematurity alone.

Some experts believe that on the basis of the data quantifying a small increase in risk of hospitalization, even for infants born earlier than 29 weeks, 0 days' gestation, palivizumab prophylaxis is not justified.

## PRETERM INFANTS WITH CLD

Prophylaxis may be considered during the RSV season during the first year of life for preterm infants who develop CLD of prematurity defined as gestational age <32 weeks, 0 days and a requirement for >21% oxygen for at least the first 28 days after birth.

During the second year of life, consideration of palivizumab prophylaxis is recommended only for infants who satisfy this definition of CLD of prematurity and continue to require medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the 6-month period before the start of the second RSV season. For infants with CLD who do not continue to require medical support in the second year of life prophylaxis is not recommended.

## INFANTS WITH HEMODYNAMICALLY SIGNIFICANT CHD

Certain children who are 12 months or younger with hemodynamically significant CHD may benefit from palivizumab prophylaxis. Children with hemodynamically significant CHD who are most likely to benefit from immunoprophylaxis include infants with acyanotic heart disease who are receiving medication to control congestive heart failure and will require cardiac surgical procedures and infants with moderate to severe pulmonary hypertension.

Decisions regarding palivizumab prophylaxis for infants with cyanotic heart defects in the first year of life may be made in consultation with a pediatric cardiologist.

These recommendations apply to qualifying infants in the first year of life who are born within 12 months of onset of the RSV season.

The following groups of infants with CHD are not at increased risk of RSV infection and generally should not receive immunoprophylaxis:

- Infants and children with hemodynamically insignificant heart disease (eg, secundum atrial septal


Prepared by Health Information Designs, LLC

defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)

- Infants with lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with mild cardiomyopathy who are not receiving medical therapy for the condition
- Children in the second year of life

Because a mean decrease in palivizumab serum concentration of 58% was observed after surgical procedures that involve cardiopulmonary bypass, for children who are receiving prophylaxis and who continue to require prophylaxis after a surgical procedure, a postoperative dose of palivizumab (15 mg/kg) should be considered after cardiac bypass or at the conclusion of extracorporeal membrane oxygenation for infants and children younger than 24 months.

Children younger than 2 years who undergo cardiac transplantation during the RSV season may be considered for palivizumab prophylaxis.

## CHILDREN WITH ANATOMIC PULMONARY ABNORMALITIES OR NEUROMUSCULAR DISORDER

No prospective studies or population-based data are available to define the risk of RSV hospitalization in children with pulmonary abnormalities or neuromuscular disease. Infants with neuromuscular disease or congenital anomaly that impairs the ability to clear secretions from the upper airway because of ineffective cough are known to be at risk for a prolonged hospitalization related to lower respiratory tract infection and, therefore, may be considered for prophylaxis during the first year of life.

## IMMUNOCOMPROMISED CHILDREN

No population based data are available on the incidence of RSV hospitalization in children who undergo solid organ or hematopoietic stem cell transplantation. Severe and even fatal disease attributable to RSV is recognized in children receiving chemotherapy or who are immunocompromised because of other conditions, but the efficacy of prophylaxis in this cohort is not known. Prophylaxis may be considered for children younger than 24 months of age who are profoundly immunocompromised during the RSV season.

## CHILDREN WITH DOWN SYNDROME

Limited data suggest a slight increase in RSV hospitalization rates among children with Down syndrome. However, data are insufficient to justify a recommendation for routine use of prophylaxis in children with Down syndrome unless qualifying heart disease, CLD, airway clearance issues, or prematurity (<29 weeks, 0 days' gestation) is present.

## CHILDREN WITH CYSTIC FIBROSIS

Routine use of palivizumab prophylaxis in patients with cystic fibrosis, including neonates diagnosed with cystic fibrosis by newborn screening, is not recommended unless other indications are present. An infant with cystic fibrosis with clinical evidence of CLD and/or nutritional compromise in the first year of life may be considered for prophylaxis. Continued use of palivizumab prophylaxis in the second year may be considered for infants with manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persist when stable) or weight for length less than the 10th percentile.

## RECOMMENDATIONS FOR TIMING OF PROPHYLAXIS FOR ALASKA NATIVE AND AMERICAN INDIAN INFANTS

On the basis of the epidemiology of RSV in Alaska, particularly in remote regions where the burden of RSV disease is significantly greater than the general US population, the selection of Alaska Native infants eligible for prophylaxis may differ from the remainder of the United States. Clinicians may wish to use RSV surveillance data generated by the state of Alaska to assist in determining onset and end of the RSV season for qualifying infants.

Limited information is available concerning the burden of RSV disease among American Indian populations. However, special consideration may be prudent for Navajo and White Mountain Apache infants in the first year of life.

## DISCONTINUATION OF PALIVIZUMAB PROPHYLAXIS AMONG CHILDREN WHO EXPERIENCE BREAKTHROUGH RSV HOSPITALIZATION

If any infant or young child receiving monthly palivizumab prophylaxis experiences a breakthrough RSV hospitalization, monthly prophylaxis should be discontinued because of the extremely low likelihood of a second RSV hospitalization in the same season (<0.5%).

## USE OF PALIVIZUMAB IN THE SECOND YEAR OF LIFE

Hospitalization rates attributable to RSV decrease during the second RSV season for all children. A second season of palivizumab prophylaxis is recommended only for preterm infants born at <32 weeks, 0 days' gestation who required at least 28 days of oxygen after birth and who continue to require


Prepared by Health Information Designs, LLC

supplemental oxygen, chronic systemic corticosteroid therapy, or bronchodilator therapy within 6 months of the start of the second RSV season.

## LACK OF THERAPEUTIC EFFICACY OF PALIVIZUMAB

Passive antibody administration is not effective in treatment of RSV disease and is not approved or recommended for this indication.

## PREVENTION OF HEALTH CARE-ASSOCIATED RSV DISEASE

No rigorous data exist to support palivizumab use in controlling outbreaks of health care-associated disease, and palivizumab use is not recommended for this purpose. Infants in a neonatal unit who qualify for prophylaxis because of CLD, prematurity, or CHD may receive the first dose 48 to 72 hours before discharge to home or promptly after discharge.

Strict adherence to infection-control practices is the basis for reducing health care-associated RSV disease.

## RSV SEASONALITY

Because 5 monthly doses of palivizumab at 15 mg/kg per dose will provide more than 6 months (>24 weeks) of serum palivizumab concentrations above the desired level for most children, administration of more than 5 monthly doses is not recommended within the continental United States. For qualifying infants who require 5 doses, a dose beginning in November and continuation for a total of 5 monthly doses will provide protection for most infants through April and is recommended for most areas of the United States. If prophylaxis is initiated in October, the fifth and final dose should be administered in February, which will provide protection for most infants through March. If prophylaxis is initiated in December, the fifth and final dose should be administered in April, which will provide protection for most infants through May.

Variation in the onset and offset of the RSV season in different regions of Florida may affect the timing of palivizumab administration. Data from the Florida Department of Health may be used to determine the appropriate timing for administration of the first dose of palivizumab for qualifying infants. Despite varying onset and offset dates of the RSV season in different regions of Florida, a maximum of 5 monthly doses of palivizumab should be adequate for qualifying infants for most RSV seasons in Florida.

Sporadic RSV infections occur throughout the year in most geographic locations. During times of low RSV prevalence (regardless of proportion of positive results), prophylaxis with palivizumab provides the least benefit because of the large number of children who must receive prophylaxis to prevent 1 RSV hospitalization.

## EFFECT OF PALIVIZUMAB PROPHYLAXIS ON SUBSEQUENT WHEEZING

Prophylaxis is not recommended for primary asthma prevention or to reduce subsequent episodes of wheezing.

## SUMMARY OF GUIDANCE

- In the first year of life, palivizumab prophylaxis is recommended for infants born before 29 weeks, 0 days' gestation.
- Palivizumab prophylaxis is not recommended for otherwise healthy infants born at or after 29 weeks, 0 days' gestation.
- In the first year of life, palivizumab prophylaxis is recommended for preterm infants with CLD of prematurity, defined as birth at <32 weeks, 0 days' gestation and a requirement for >21% oxygen for at least 28 days after birth.
- Clinicians may administer palivizumab prophylaxis in the first year of life to certain infants with hemodynamically significant heart disease.
- Clinicians may administer up to a maximum of 5 monthly doses of palivizumab (15 mg/kg per dose) during the RSV season to infants who qualify for prophylaxis in the first year of life. Qualifying infants born during the RSV season may require fewer doses. For example, infants born in January would receive their last dose in March.
- Palivizumab prophylaxis is not recommended in the second year of life except for children who required at least 28 days of supplemental oxygen after birth and who continue to require medical intervention (supplemental oxygen, chronic corticosteroid, or diuretic therapy).
- Monthly prophylaxis should be discontinued in any child who experiences a breakthrough RSV hospitalization.
- Children with pulmonary abnormality or neuromuscular disease that impairs the ability to clear secretions from the upper airways may be considered for prophylaxis in the first year of life.
- Children younger than 24 months who will be profoundly immunocompromised during the RSV season may be considered for prophylaxis.
- Insufficient data are available to recommend palivizumab prophylaxis for children with cystic fibrosis or Down syndrome.
- The burden of RSV disease and costs associated with transport from remote locations may result in a broader use of palivizumab for RSV prevention in Alaska Native


Prepared by Health Information Designs, LLC

populations and possibly in selected other American Indian populations.

- Palivizumab prophylaxis is not recommended for prevention of health care-associated RSV disease.

### COMMITTEE ON INFECTIOUS DISEASES, 2013–2014

Michael T. Brady, MD, FAAP – Chairperson, *Red Book* Associate Editor
Carrie L. Byington, MD, FAAP
H. Dele Davies, MD, FAAP
Kathryn M. Edwards, MD, FAAP
Mary Anne Jackson, MD, FAAP – *Red Book* Associate Editor
Yvonne A. Maldonado, MD, FAAP
Dennis L. Murray, MD, FAAP
Walter A. Orenstein, MD, FAAP
Mobeen H. Rathore, MD, FAAP
Mark H. Sawyer, MD, FAAP
Gordon E. Schutze, MD, FAAP
Rodney E. Willoughby, MD, FAAP
Theoklis E. Zaoutis, MD, FAAP

### EX OFFICIO

Henry H. Bernstein, DO, MHCM, FAAP – *Red Book Online* Associate Editor
David W. Kimberlin, MD, FAAP – *Red Book* Editor
Sarah S. Long, MD, FAAP – *Red Book* Associate Editor
H. Cody Meissner, MD, FAAP – *Visual Red Book* Associate Editor

### LIAISONS

Marc A. Fischer, MD, FAAP – *Centers for Disease Control and Prevention*
Bruce G. Gellin, MD, MPH – *National Vaccine Program Office*
Richard L. Gorman, MD, FAAP – *National Institutes of Health*
Lucia H. Lee, MD, FAAP – *Food and Drug Administration*
R. Douglas Pratt, MD – *Food and Drug Administration*
Jennifer S. Read, MD, MS, MPH, DTM&H FAAP – *Food and Drug Administration*
Joan L. Robinson, MD – *Canadian Pediatric Society*
Marco Aurelio Palazzi Safadi, MD – *Sociedad Latinoamericana de Infectologia Pediatrica*
Jane F. Seward, MBBS, MPH, FAAP – *Centers for Disease Control and Prevention*
Jeffrey R. Starke, MD, FAAP – *American Thoracic Society*
Geoffrey R. Simon, MD, FAAP – *Committee on Practice Ambulatory Medicine*
Tina Q. Tan, MD, FAAP – *Pediatric Infectious Diseases Society*

### CONTRIBUTORS

Joseph A. Bocchini, MD, FAAP
W. Robert Morrow, MD, FAAP – Chairperson, *Section on Cardiology*
Larry K. Pickering, MD, FAAP
Geoffrey L. Rosenthal, MD, PhD, FAAP – *Section on Cardiology*
Dan L. Stewart, MD, FAAP – *Committee on Fetus and Newborn*
Almut Winterstein, PhD

### STAFF

Jennifer M. Frantz, MPH

### SUBCOMMITTEE ON BRONCHIOLITIS

Shawn L. Ralston, MD, FAAP – Chairperson, *Pediatric Hospitalist*
Allan S. Lieberthal MD, FAAP – Chairperson, *General Pediatrician with expertise in pulmonology*
H. Cody Meissner, MD, FAAP – *Pediatric Infectious Disease Physician; AAP Committee on Infectious Diseases Representative*
Brian K. Alverson, MD, FAAP – *Pediatric Hospitalist, AAP Section on Hospital Medicine Representative*
Jill E. Baley, MD, FAAP – *Neonatal-Perinatal Medicine, AAP Committee on Fetus and Newborn Representative*
Anne M. Gadomski MD, MPH, FAAP – *General Pediatrician and Research Scientist*
David W. Johnson, MD, FAAP – *Pediatric Emergency Medicine Physician*
Michael J. Light, MD, FAAP – *Pediatric Pulmonologist; AAP Section on Pediatric Pulmonology Representative*
Nizar F. Maraqa, MD, FAAP – *Pediatric Infectious Disease Physician; AAP Section on Infectious Diseases Representative*
Eneida A. Mendonca, MD, PhD, FAAP, FACMI – *Informatician/Academic Pediatric Intensive Care Physician; Partnership for Policy Implementation Representative*
Kieran J. Phelan, MD, MSc – *General Pediatrician*
Joseph J. Zorc, MD, MSCE, FAAP – *Pediatric Emergency Physician; AAP Section on Emergency Medicine Representative*
Danette Stanko-Lopp, MA, MPH – *Methodologist, Epidemiologist*
Sinsi Hernández-Cancio, JD – *Parent/Consumer Representative*

### LIAISONS

Mark A. Brown, MD – *Pediatric Pulmonologist; American Thoracic Society Liaison*
Ian Nathanson, MD, FAAP – *Pediatric Pulmonologist; American College of Chest Physicians Liaison*
Elizabeth Rosenblum, MD – *Academic Family Physician, American Academy of Family Physicians Liaison*
Stephen Sayles III MD, FACEP – *Emergency Medicine Physician; American College of Emergency Physicians Liaison*

### STAFF

Caryn Davidson, MA

## REFERENCES


1. Cassel CK, Guest JA. Choosing wisely: helping physicians and patients make smart decisions about their care. *JAMA*. 2012;307(17):1801–1802
2. ABIM Foundation. American Board of Internal Medicine; ACP-ASIM Foundation. American College of Physicians-American Society of Internal Medicine; European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med*. 2002;136(3):243–246
3. Ubel PA, Jagsi R. Promoting population health through financial stewardship. *N Engl J Med*. 2014;370(14):1280–1281
4. American Academy of Pediatrics, Committee on Infectious Diseases and Bronchiolitis Guidelines Committee. Technical report: updated guidance for palivizumab prophylaxis among infants and young children at increased risk of hospitalization for respiratory syncytial virus infection. *Pediatrics*. 2014; (in press)
5. American Academy of Pediatrics. Respiratory syncytial virus. In: Pickering LK, Baker CJ, Kimberlin DW, Long SS, eds. *Red Book: 2012 Report of the Committee on Infectious Diseases*. Elk Grove Village, IL: American Academy of Pediatrics; 2012: 609–618
6. American Academy of Pediatrics Subcommittee on Diagnosis and Management of Bronchiolitis. Diagnosis and management of bronchiolitis. *Pediatrics*. 2006;118(4):1774–1793
7. Synagis Package Insert. Gaithersburg, MD: MedImmune; April 2013. Available at: www.medimmune.com/docs/default-source/pdfs/prescribing-information-for-synagis.pdf. Accessed April 24, 2014
8. American Academy of Pediatrics Committee on Infectious Diseases and Committee on Fetus and Newborn. Revised indications for the use of palivizumab and respiratory



Prepared by Health Information Designs, LLC

syncytial virus immune globulin intravenous for the prevention of respiratory syncytial virus infections. *Pediatrics*. 2003;112(6 pt 1): 1442–1446

9. American Academy of Pediatrics Committee on Infectious Diseases and Committee of Fetus and Newborn. Prevention of respiratory syncytial virus infections: indications for the use of palivizumab and update on the use of RSV-IGIV. *Pediatrics*. 1998;102(5):1211–1216
10. American Academy of Pediatrics. Respiratory syncytial virus. In: Pickering LK, Baker CJ, Long SS, McMillan JA, eds. *Red Book: 2006 Report of the Committee on Infectious Diseases*. Elk Grove Village, IL: American Academy of Pediatrics; 2006:560–566
11. Committee on Infectious Diseases. From the American Academy of Pediatrics: Policy statements–Modified recommendations for use of palivizumab for prevention of respiratory syncytial virus infections. *Pediatrics*. 2009;124(6):1694–1701

*(Continued from first page)*

www.pediatrics.org/cgi/doi/10.1542/peds.2014-1665

doi:10.1542/peds.2014-1665

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

Copyright © 2014 by the American Academy of Pediatrics



Prepared by Health Information Designs, LLC

**Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection**

COMMITTEE ON INFECTIOUS DISEASES AND BRONCHIOLITIS GUIDELINES COMMITTEE

*Pediatrics*; originally published online July 28, 2014;
DOI: 10.1542/peds.2014-1665

| | |
|---|---|
| **Updated Information & Services** | including high resolution figures, can be found at: http://pediatrics.aappublications.org/content/early/2014/07/23/peds.2014-1665 |
| **Citations** | This article has been cited by 1 HighWire-hosted articles: http://pediatrics.aappublications.org/content/early/2014/07/23/peds.2014-1665#related-urls |
| **Permissions & Licensing** | Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at: http://pediatrics.aappublications.org/site/misc/Permissions.xhtml |
| **Reprints** | Information about ordering reprints can be found online: http://pediatrics.aappublications.org/site/misc/reprints.xhtml |

PEDIATRICS is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1948. PEDIATRICS is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2014 by the American Academy of Pediatrics. All rights reserved. Print ISSN: 0031-4005. Online ISSN: 1098-4275.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

HEALTH INFORMATION DESIGNS

# SYNAGIS WEB BASED FORM

**For questions regarding this Prior Authorization Call 701-328-4023**

Prior Authorization Vendor for ND Medicaid

Note:

- Synagis season will be October 19th through April 21st
- Providers will choose when to start dosing Synagis based on prevalence of RSV in the community
- Clinicians may administer up to a maximum of 5 monthly doses during the RSV season.
- Qualifying infants born during the RSV season may require fewer doses.

**TO BE COMPLETED BY PRESCRIBER**

| Recipient Medicaid ID Number | Recipient Date of Birth | Prescriber NPI | Prescriber Fax Number |
|---|---|---|---|
| | | | |

Diagnosis (qualification for Synagis)

___ **Prematurity**

<29 weeks, 0 days gestational age – Synagis allowed if younger than 12 months of age at start of RSV season (max of 5 doses)

**Gestational Age (e.g. 28 weeks, 4 days)**

**Weeks** _____ **Days** _____

___ **Chronic Lung Disease of Prematurity (CLD)** – Child ≤12 months old with gestational age <32 weeks, 0 days and requires supplemental oxygen >21% for at least the first 28 days after birth.

___ **Chronic Lung Disease of Prematurity (CLD**) – Child ≤24 months old with gestational age <32 weeks, 0 days and requires supplemental oxygen >21% for at least the first 28 days after birth and continues to receive medical support within six months before the start of RSV season.

___ Supplemental Oxygen

___ Diuretic

___ Chronic corticosteroid therapy

___ **Congenital Heart Disease (CHD)**

Child ≤12 months old with hemodynamically significant cyanotic or acyanotic CHD

Medical Therapy Required _____

*children less than 24 months who undergo cardiac transplantation during RSV season may be considered for prophylaxis.

___ **Neuromuscular disease** (may be considered for prophylaxis during the first year of life)

___ **Pulmonary abnormalities** (may be considered for prophylaxis during the first year of life)

___ **Profoundly Immunocompromised children** (children <24 months of age may be considered for prophylaxis during the RSV season)

***Accessed online at pediatrics.aappublications.org**

| Report Dates: 01/01/14 - 06/30/14 | |
|---|---|
| Overlapping Timeframe: 60 | |
| Total Days Supply: 1 | |
| Consecutive Days Difference in Prescriptions: 10 | |
| Number of Therapies: At Least 2 | |
| Number of Recipients: 99 | |
| **Drug Names** | **Count of Overlaps** |
| ALPRAZOLAM , ALPRAZOLAM ER | 1 |
| ALPRAZOLAM , ALPRAZOLAM ER , LORAZEPAM , TEMAZEPAM | 4 |
| ALPRAZOLAM , CLONAZEPAM | 31 |
| ALPRAZOLAM , CLONAZEPAM , DIAZEPAM | 3 |
| ALPRAZOLAM , CLONAZEPAM , DIAZEPAM , TEMAZEPAM | 1 |
| ALPRAZOLAM , CLONAZEPAM , LORAZEPAM | 4 |
| ALPRAZOLAM , DIAZEPAM | 5 |
| ALPRAZOLAM , DIAZEPAM , LORAZEPAM | 2 |
| ALPRAZOLAM , LORAZEPAM | 11 |
| ALPRAZOLAM , TEMAZEPAM | 4 |
| ALPRAZOLAM , TRIAZOLAM | 3 |
| ALPRAZOLAM ER , CLONAZEPAM | 7 |
| CHLORDIAZEPOXIDE HCL , CLONAZEPAM | 4 |
| CHLORDIAZEPOXIDE HCL , LORAZEPAM | 2 |
| CHLORDIAZEPOXIDE HCL , LORAZEPAM , TEMAZEPAM | 2 |
| CLONAZEPAM , DIAZEPAM | 19 |
| CLONAZEPAM , DIAZEPAM , LORAZEPAM | 6 |
| CLONAZEPAM , LORAZEPAM | 42 |
| CLONAZEPAM , LORAZEPAM , LORAZEPAM INTENSOL | 6 |
| CLONAZEPAM , LORAZEPAM , TEMAZEPAM | 3 |
| CLONAZEPAM , LORAZEPAM INTENSOL | 2 |
| CLONAZEPAM , MIDAZOLAM HCL | 3 |
| CLONAZEPAM , TEMAZEPAM | 4 |
| CLONAZEPAM , TRIAZOLAM | 1 |
| DIAZEPAM , LORAZEPAM | 10 |
| DIAZEPAM , TEMAZEPAM | 3 |
| DIAZEPAM , TEMAZEPAM , TRIAZOLAM | 3 |
| FLURAZEPAM HCL , LORAZEPAM | 1 |
| LORAZEPAM , TEMAZEPAM | 3 |

| Top 20 Prescribers of duplicate benzodiazepine therapy | |
|---|---|
| **Prescriber** | **City** |
| Neurologist | Fargo |
| Pediatrician | Jamestown |
| Psychiatrist | Fargo |
| Psychiatrist | Bismarck |
| Psychiatrist | Fargo |
| NP | Fargo |
| Psychiatrist | Grand Forks |
| Family Medicine | Bismarck |
| Psychiatrist | Grand Forks |
| Psychiatrist | Fargo |
| NP | Bismarck |
| Internal Medicine | Fargo |
| NP | Bismarck |
| Psychiatrist | Bismarck |
| NP | Minot |
| Family Medicine | Valley City |
| PA | Fargo |
| Family Medicine | Wahpeton |
| Psychiatrist | Bismarck |
| Neurologist | Grand Forks |
| | |
| **Duplicate benzodiazepine therapy - age ranges** | |
| **Age Range** | **Recipient Count** |
| 0-10 | 4 |
| 11-20 | 5 |
| 21-30 | 11 |
| 31-40 | 23 |
| 41-50 | 27 |
| 51-60 | 19 |
| 61+ | 10 |
| | |
| **Top 20 diagnoses** | **Count** |
| ENCOUNTER LONG TERM USE OTH DRUGS | 551 |
| ANXIETY STATE UNSPECIFIED | 462 |
| UNSPECIFIED ESSENTIAL HYPERTENSION | 456 |
| TOBACCO USE DISORDER | 370 |
| DEPRESSIVE DISORDER OTHER | 349 |
| ABDOMINAL PAIN UNS SITE | 322 |
| LUMBAGO | 304 |
| UNSPEC CHEST PAIN | 301 |
| DIABETES UNCOMPL TYPE II | 301 |
| HEADACHE | 299 |
| PNEUMONIA ORGANISM UNSPECIFIED | 284 |
| URINARY TRACT INFECTION UNSPEC | 236 |
| UNS MYALGIA/MYOSITIS | 230 |
| DIARRHEA | 223 |
| POSTTRAUMATIC STRESS DISORDER | 215 |
| CERVICALGIA | 212 |
| RHEUMATOID ARTHRITIS | 210 |
| ASTHMA UNSPECIFIED | 210 |
| PAIN IN LIMB | 200 |
| GENERALIZED ANXIETY DISORDER | 192 |

# TOPICAL TESTOSTERONE
# PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
|---|---|---|---|
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |

| **Requested Drug and Dosage:** | **Diagnosis for this Request:** |
|---|---|
| □ ANDRODERM_____ □ ANDROGEL_____<br>□ FORTESTA_____ □ TESTIM_____<br>□ 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 Signature | Date |
|---|---|

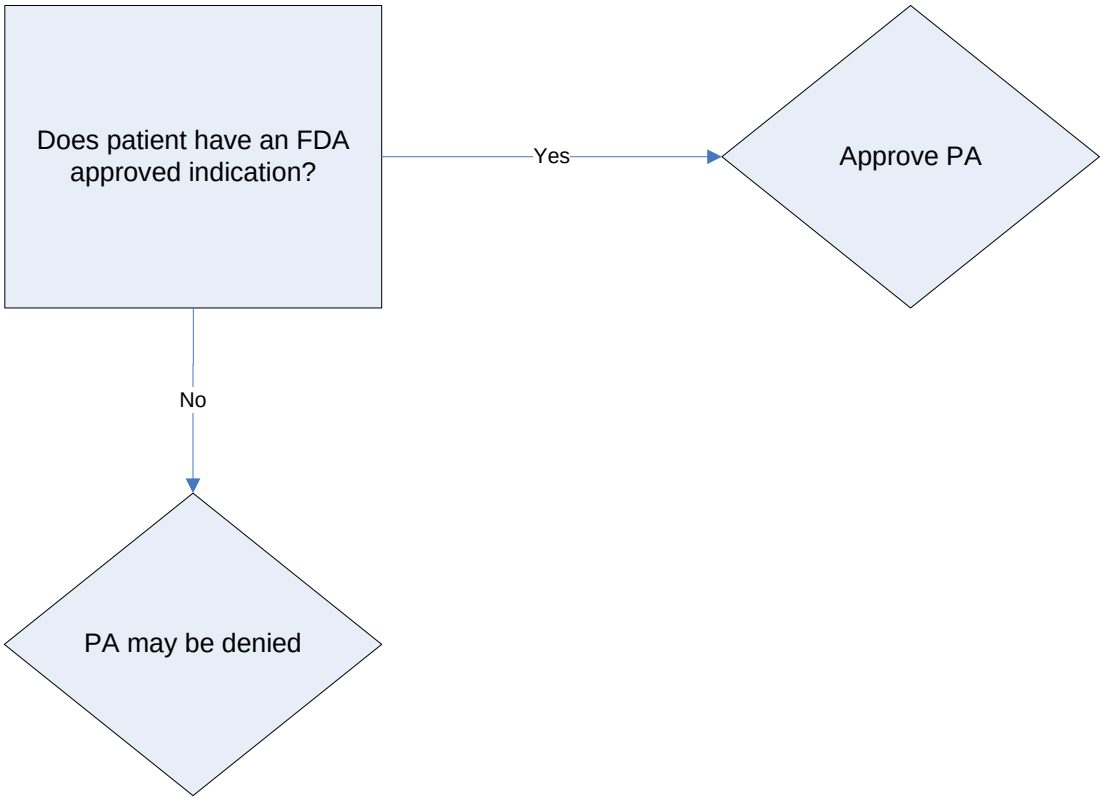
**Part II: TO BE COMPLETED BY PHARMACY**

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

**Part III: FOR OFFICIAL USE ONLY**

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

# North Dakota Department of Human Services
# Topical Testosterone Prior Authorization Algorithm



# PHOSPHATE BINDERS
# PA FORM

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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.**

**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:** | **Diagnosis for this Request:** |
|---|---|
| □ RENAGEL _____<br>□ FOSRENOL_____<br>□ RENVELA _____<br>□ VELPHORO _____ | |

□ *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 |
|---|---|

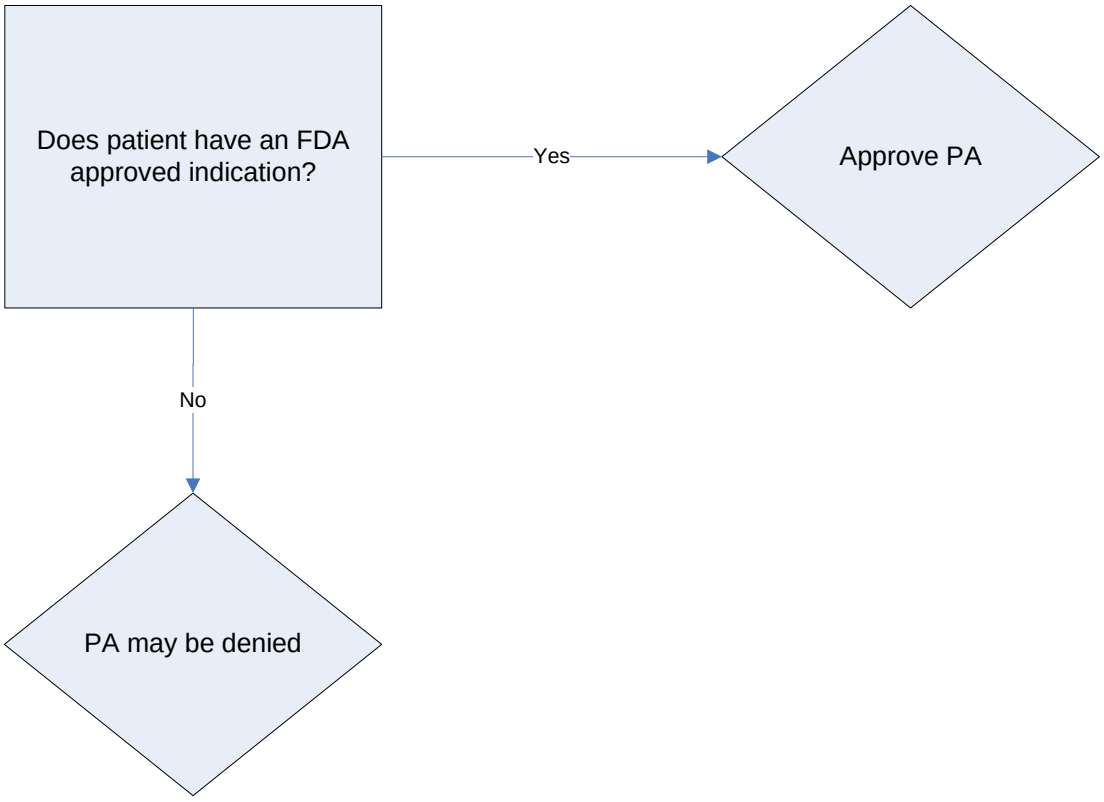
**Part II: TO BE COMPLETED BY PHARMACY**

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

**Part III: FOR OFFICIAL USE ONLY**

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

# North Dakota Department of Human Services
# Phosphate Binders Authorization Algorithm



**ZONTIVITY**
**PA FORM**

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
|---|---|---|---|
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ ZONTIVITY | **Diagnosis for this Request:** | | |
| **Using in combination with:**<br>□ 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 Signature | | Date | |

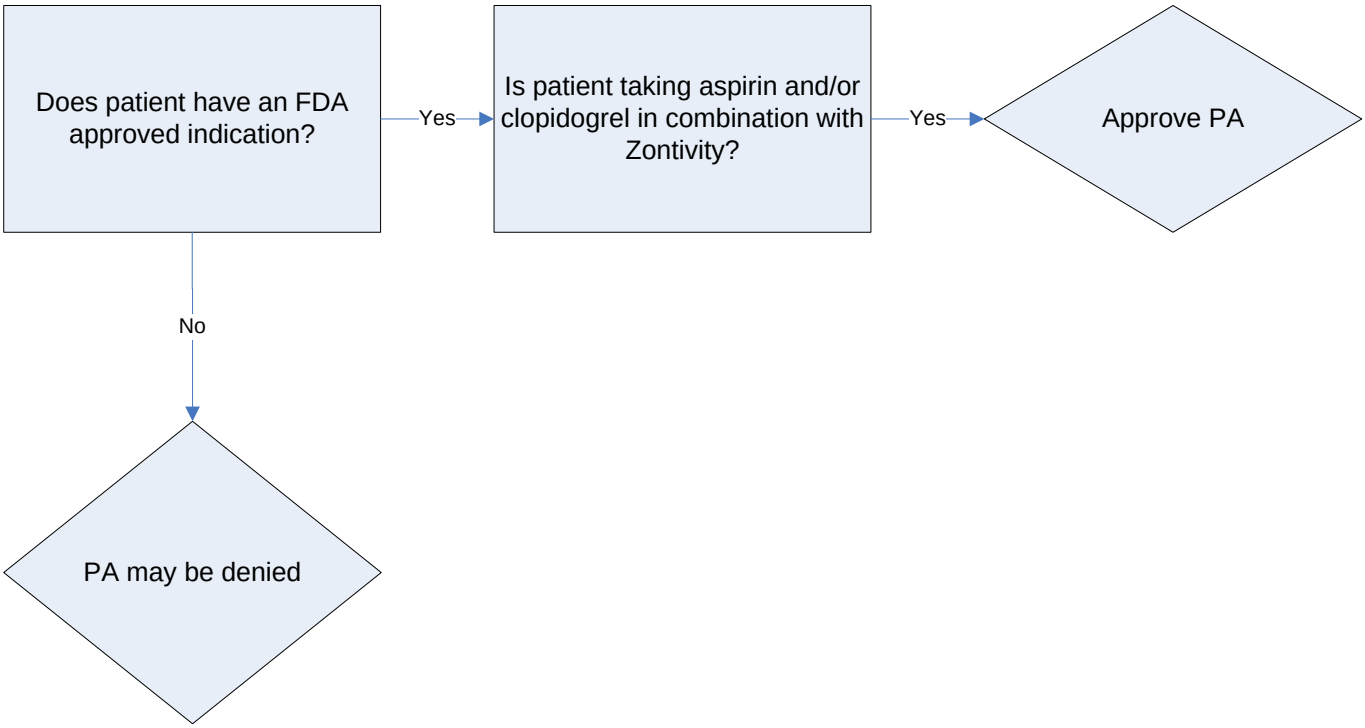
**Part II: TO BE COMPLETED BY PHARMACY**

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

**Part III: FOR OFFICIAL USE ONLY**

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

# North Dakota Department of Human Services
# Zontivity Prior Authorization Algorithm



**EVZIO**
**PA FORM**

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
|---|---|---|---|
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ EVZIO | **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 Signature | | Date | |

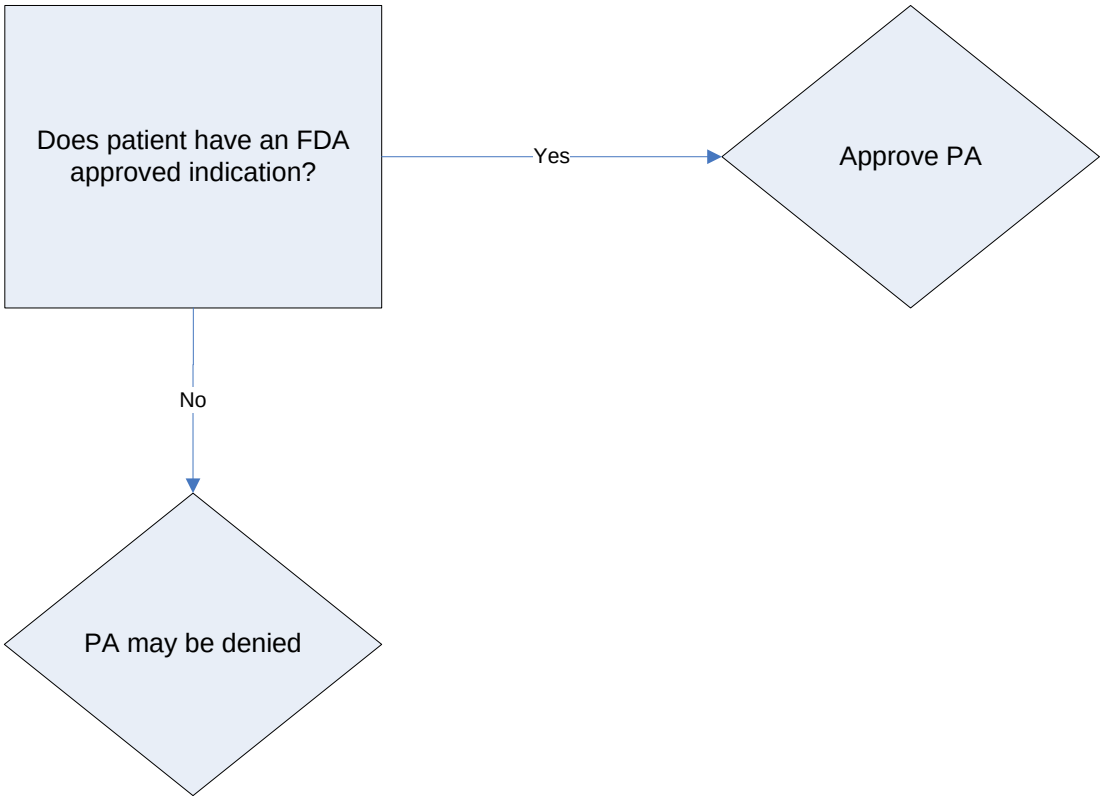
**Part II: TO BE COMPLETED BY PHARMACY**

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

**Part III: FOR OFFICIAL USE ONLY**

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

# North Dakota Department of Human Services
# Evzio Prior Authorization Algorithm



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

HEALTH INFORMATION DESIGNS

**Fax Completed Form to: 866-254-0761**
**For questions regarding this Prior authorization, call 866-773-0695**

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for Aceon must try at least two generic ACE-Is as first line.
ND Medicaid requires that patients receiving an ARB or Renin Inhibitor must try and fail one ACE-I.
***Note:**

- **ACE-I: Captopril, enalapril, moexipril, ramipril, lisinopril, trandolapril, quinapril, benazepril, and fosinopril and their hydrochlorothiazide containing combinations do not require a prior authorization.**
- **Angiotensin II receptor antagonists: Cozaar, Micardis, Teveten, Atacand, Diovan, Avapro, Benicar, Edarbi and their hydrochlorothiazide containing combinations.**
- **Renin Inhibitor: Tekturna and Tekturna HCT.**

**Part I: TO BE COMPLETED BY PRESCRIBER**

| Recipient Name | Recipient Date of Birth | Recipient Medicaid ID Number | |
|---|---|---|---|
| Prescriber Name | | | |
| Prescriber Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:** | **Diagnosis for this request:** | | |

**Qualifications for coverage:**

| □ Failed ACE-I therapy (list two ACE-I to receive Aceon) | 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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# ACTINIC KERATOSIS PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
|---|---|---|---|
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ ZYCLARA<br>□ SOLARAZE<br>□ PICATO | **Diagnosis 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# AMPYRA PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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**

**Part I: TO BE COMPLETED BY PHYSICIAN**

| | | | |
|---|---|---|---|
| Recipient Name | **Recipient Date of Birth** | Recipient Medicaid ID Number | |
| Physician Name | Specialist involved in therapy (if not treating physician) | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ AMPYRA | **FDA approved indication for this request:** | | |
| **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)?** | | | |
| 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 -<br>Effective dates of PA:<br>From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

**AMRIX PA Form**

**Fax Completed Form to:**
**866-254-0761**
**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 MEDICAID ID NUMBER: |
| Address: | Phone: ( ) |
| City: | FAX: ( ) |
| State: Zip: | |
| **REQUESTED DRUG:** | **Requested Dosage:** (must be completed) |

**Qualifications for coverage:**

| | | |
|---|---|---|
| ❑ Failed cyclobenzaprine therapy | Start Date:<br>End Date: | Dose:<br>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 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 -<br>Effective dates of PA: | From: / / | To: / / |
| Denied: (Reasons) | | |

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

# ANTIHISTAMINE PA FORM

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

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. Patients must use fexofenadine as step 2 after loratadine or cetirizine failure.***
- ***Net cost to Medicaid: Loratadine = cetirizine << Allegra (generic) << Clarinex = Xyzal***

**Part I: TO BE COMPLETED BY PRESCRIBER**

| | |
|---|---|
| RECIPIENT NAME: | RECIPIENT MEDICAID ID NUMBER: |
| Recipient Date of birth: / / | |
| PRESCRIBER NAME: | PRESCRIBER MEDICAID ID NUMBER: |
| Address: | Phone: ( ) |
| City: | FAX: ( ) |
| State: Zip: | |
| **REQUESTED DRUG:**<br>□ **ALLEGRA (GENERIC)** □ **CLARINEX** □ **XYZAL** | **Requested Dosage:** (must be completed)<br>**Diagnosis for this request:** |

**Qualifications for coverage:**

| | | |
|---|---|---|
| □ Failed loratadine or cetirizine (include which agent failed)_____ | Start Date: | End Date: |
| □ Failed Allegra (generic) Step 2 | 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 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) | | |

HEALTH INFORMATION DESIGNS

# Aubagio Prior Authorization

**Fax Completed Form to:**
**866-254-0761**
**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:

***Note:***

- ***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.***

**Part I: TO BE COMPLETED BY PHYSICIAN**

| | | | |
|---|---|---|---|
| Recipient Name | Recipient Date of Birth | Recipient Medicaid ID Number | |
| Physician Name | Neurologist involved in therapy: | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Qualifications for coverage:** | | | |
| **Requested Drug and Dosage:**<br>□ **Aubagio** | **Diagnosis for this request:** | | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

**Asacol HD Prior Authorization**

**Fax Completed Form to:**
**866-254-0761**
**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 Asacol.
***Note:***

- ***Asacol is FDA approved to treat mild to moderate flares and maintain remission of ulcerative colitis.***
- ***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 | |
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br><br>□ **Asacol HD** | **Diagnosis for this request:** | | |
| **Qualifications for coverage:** | | | |
| □ FAILED ASACOL THERAPY<br><br>START DATE:<br>END DATE: | DOSE:<br>FREQUENCY: | | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# BLOOD FACTOR PRODUCTS PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
| Physician Name | | | |
| Physician Medicaid Provider Number | 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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Brisdelle**
**Prior Authorization**

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

ND Medicaid requires that patients receiving a new prescription for Brisdelle must meet the following criteria:

- *Patient must first try paroxetine*

**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 |
| **QUALIFICATIONS FOR COVERAGE:** | | | |

| Requested Drug and Dosage:<br><br>□ **Brisdelle** | Diagnosis for this request: |
|---|---|
| Failed Therapy: | Start Date:<br><br>End Date: |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

**BUPRENORPHINE OR BUPRENORPHINE/NALOXONE COMBINATIONS PA FORM**

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

ND Medicaid requires that patients receiving a new prescription for buprenorphine containing products 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 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 | |
| Physician Name | **(SAMHSA ID)** | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ SUBOXONE/ZUBSOLV □ SUBUTEX | **FDA Approved Indication for this request:** | | |
| □ Patient is not taking other opioids, tramadol, or carisoprodol concurrently with buprenorphine containing products. | | | |
| 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# CARISOPRODOL PA FORM


Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
|---|---|---|---|
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ 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.* | | | |
| 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# CIALIS for BENIGN PROSTATIC HYPERPLASIA
# PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
|---|---|---|---|
| Physician Name | | | |
| Physician Medicaid Provider Number | 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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# COMBINATION PRODUCTS
# PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
| Physician Name | | | |
| Physician Medicaid Provider Number | 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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Agents Used to Treat COPD**
**Prior Authorization**

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

ND Medicaid requires that patients receiving a new prescription for Arcapta, Brovana, Spiriva, Tudorza, Anoro Ellipta, or Breo Ellipta must meet the following criteria:

- *Patient must have a diagnosis of COPD.*

**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 |

**QUALIFICATIONS FOR COVERAGE:**

| Requested Drug and Dosage: | Diagnosis for this request: |
|---|---|
| □ **Arcapta** □ **Tudorza**<br>□ **Brovana** □ **Breo Ellipta**<br>□ **Spiriva** □ **Anoro Ellipta** | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

# BRAND NAME NSAID/COX-II PA FORM

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

ND Medicaid requires that patients using brand name NSAIDs or COX-II drugs must use a generic NSAID as 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 Medicaid Provider Number | 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:**

| | | | | |
|---|---|---|---|---|
| □ 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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

**Daliresp Prior Authorization**

**Fax Completed Form to:**
**866-254-0761**
**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 Daliresp must follow the following guidelines:

- ***Patient must be 18 years of age or older.***
- ***Patient must have a diagnosis of severe COPD associated with chronic bronchitis and a history of exacerbations.***

**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:**<br>□ **Daliresp** | **Diagnosis for this request:** | | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Diclegis**
**Prior Authorization**

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

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*

**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 |
| **QUALIFICATIONS FOR COVERAGE:** | | | |
| Requested Drug and Dosage:<br>□ **Diclegis** | | Diagnosis for this request: | |
| Failed Therapy: | | Start Date:<br>End Date: | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

**DISPENSE AS WRITTEN**
**PA FORM**

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

Prior Authorization Vendor for ND Medicaid

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 Medicaid Provider Number | | Telephone Number | Fax Number | |
| Address | | City | State | Zip Code |
| **Requested Drug:** | **DOSAGE:** | **Diagnosis for this request:** | | |

| **QUALIFICATIONS FOR COVERAGE:**<br>□ 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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# DIFICID PA FORM


Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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**

**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:**<br>□ DIFICID | **Diagnosis for this Request:** | **Failed therapy:**<br><br>**Start Date:**<br>**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 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 -<br>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:**
**866-254-0761**
**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 | |
|---|---|---|---|
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ DEXPAK<br>□ ZEMA-PAK | **Diagnosis for this Request:** | | |
| **Failed Therapy (dose and frequency):**<br>□ DEXAMETHASONE | **Start Date:**<br>**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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# ELAPRASE PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
|---|---|---|---|
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br><br>□ 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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Epinephrine Auto Injectors**
**Prior Authorization**

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

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 | |
|---|---|---|---|
| Physician Name: | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **QUALIFICATIONS FOR COVERAGE:** | | | |
| Requested Drug and Dosage:<br>□ | | Diagnosis for this request: | |
| Failed Therapy: | | Start Date:<br>End Date: | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fulyzaq**
**Prior Authorization**

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

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 | |
|---|---|---|---|
| Physician Name: | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **QUALIFICATIONS FOR COVERAGE:** | | | |
| Requested Drug and Dosage:<br>□ **Fulyzaq** | Diagnosis for this request:<br>Anti-retroviral therapy | | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

# Genitourinary Smooth Muscle Relaxants (GSM) Prior Authorization

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed GSMs must follow these guidelines:
***Note:***

- **Patient must have an FDA approved indication for the medication requested.**
- **Patient must try oxybutynin or oxybutynin ER.**

**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 |
| **Qualifications for coverage:** | | | |
| **Requested Drug and Dosage:**<br>□ **Enablex** □ **Detrol LA**<br>□ **Toviaz** □ **Gelnique**<br>□ **Myrbetriq** □ **Oxytrol**<br>□ **Detrol** □ **Sanctura**<br>□ **Vesicare** □ **Sanctura XR** | **Diagnosis for this request:**<br><br>**Failed therapy (Drug and Dose)**<br><br>**Start Date:** **End Date:** | | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Giazo**
**Prior Authorization**

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

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 | |
|---|---|---|---|
| Physician Name: | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **QUALIFICATIONS FOR COVERAGE:** | | | |
| Requested Drug and Dosage:<br>□ Giazo | | Diagnosis for this request: | |
| □ Failed trial of balsalazide 750mg capsules<br>Dose: | | | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

# Gilenya Prior Authorization

**Fax Completed Form to:**
**866-254-0761**
**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 or irregular heart beat.***
- ***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***

**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:**<br>□ **Gilenya** | **Diagnosis for this request:** | | |
| **Qualifications for coverage:** | | | |
| **Current electrocardiogram**<br>**Date:** | **Current CBC**<br>**Date:** | **Ophthalmologic Evaluation**<br>**Date:** | **Transaminase/Bilirubin levels**<br>**Date:** |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# GRALISE PA FORM


Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
|---|---|---|---|
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br><br>□ GRALISE | **Diagnosis for this Request:** | | |
| **Failed Therapy (dose and frequency):**<br><br>□ GABAPENTIN | **Start Date:**<br><br>**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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

## Growth Hormone PA Form

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

Prior Authorization Vendor for ND Medicaid

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 MEDICAID ID NUMBER: |
| Address: | | Phone: ( ) |
| City: | | FAX: ( ) |
| State: Zip: | | |

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

**Qualifications for coverage:**

| | | |
|---|---|---|
| Criteria met: | Diagnosis Date:<br>Drug: | Dose:<br>Frequency: |
| 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 -<br>Effective dates of PA: From: / / | | To: / / |
| Denied: (Reasons) | | |
| | | |

# HARVONI PA FORM


Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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) 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.
- 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 | |
|---|---|---|---|
| Physician Name | Specialist involved in therapy | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |

| **Requested Drug**<br>□ **Harvoni**<br>Dosage: _____ | **Documented liver fibrosis:** | **Diagnosis for this request:**<br>**Genotype:** | **Patient is drug and alcohol free for past 12 months:**<br>□ YES □ NO<br>**eGFR:** |
|---|---|---|---|

| Has the patient been previously treated for chronic hepatitis C?<br>□ YES □ NO<br>If yes, please indicate past treatment regimen(s), dates of treatment, and response to therapy: | Baseline HCV RNA:<br>HCV RNA 4 weeks after starting therapy: |
|---|---|
| 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

# Hepatitis C Virus (HCV) Medication Prior Authorization

**Fax Completed Form to:**
**866-254-0761**
**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, PegIntron, Incivek, or Victrelis 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.***
- ***Incivek and Victrelis patients must be 18 years of age or older.***
- ***Incivek and Victrelis patients must also be taking ribavirin and peg-interferon.***
- ***Incivek and 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 | |
|---|---|---|---|
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ **Intron** □ **Pegasys**<br>□ **Infergen** □ **PEGIntron**<br>□ **Incivek** □ **Victrelis** | **Diagnosis for this request:** | **Genotype:** | |
| | **Ribavirin dose:**<br>**Peg-interferon dose:** | | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# HEREDITARY ANGIOEDEMA
# PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
|---|---|---|---|
| Physician Name | Specialist Involved in therapy: | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ BERINERT □ FIRAZYR<br>□ 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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

**Horizant Prior Authorization**

**Fax Completed Form to:**
**866-254-0761**
**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 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 | |
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br><br>□ **Horizant** | **Diagnosis for this request:** | | |
| **Qualifications for coverage:** | | | |
| □ FAILED THERAPY<br><br>START DATE:<br>END DATE: | DOSE:<br>FREQUENCY: | | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# TARGETED IMMUNE MODULATORS PA FORM


Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

ND Medicaid requires that patients receiving a new prescription for Actemra, Orencia, Humira, Enbrel, Amevive, Kineret, Cimzia, Remicade, 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 | |
|---|---|---|---|
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ ORENCIA □ AMEVIVE<br>□ ENBREL □ CIMZIA<br>□ KINERET □ REMICADE<br>□ HUMIRA □ SIMPONI<br>□ STELARA □ ACTEMRA | **FDA Approved Indication 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.* | | | |
| 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# KALYDECO PA FORM


Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 have a G551D mutation in the cystic fibrosis conductance regulator (CFTR) gene.**

**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:**<br><br>□ 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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# KAPVAY PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br><br>□ KAPVAY | **Diagnosis for this Request:** | | |
| **Failed Therapy (dose and frequency):**<br><br>□ | **Start Date:**<br><br>**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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# KETEK PA FORM

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

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 MEDICAID ID NUMBER: |
| Address: | Phone: ( ) |
| City: | FAX: ( ) |
| State: Zip: | |

| | |
|---|---|
| **REQUESTED DRUG:**<br>□ **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.

□ 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 -<br>Effective dates of PA: From: / / | To: / / |
| Denied: (Reasons) | |

# KUVAN PA FORM


Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
|---|---|---|---|
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br><br>□ KUVAN | **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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# LORZONE PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br><br>□ LORZONE | **Diagnosis for this Request:** | | |
| **Failed Therapy (dose and frequency):**<br><br>□ CHLORZOXAZONE | **Start Date:**<br><br>**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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# METOZOLV ODT PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |

| | | | |
|---|---|---|---|
| **Requested Drug and Dosage:**<br><br>□ 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.* | | | |
| 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# MOXATAG PA FORM


Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
|---|---|---|---|
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |

| **REQUESTED DRUG :**<br><br>□ MOXATAG | **Dosage** |
|---|---|
| **Qualifications for coverage:** | |
| □ Allergic/intolerable side effects to inactive ingredients of regular-release amoxicillin.<br><br>Name of inactive ingredient:<br><br>_____ | 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.* | |
| 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# BRAND-NAME NARCOTICS PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

ND Medicaid requires that patients receiving a new prescription for a brand-name narcotic must meet the following criteria:

- **Documented failure of a 30-day trial of a generic narcotic.**

**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:**

□ EMBEDA □ OPANA ER □ KADIAN □ AVINZA □ EXALGO □ FENTORA □ ONSOLIS □ MAGNACET □ BUTRANS

□ OTHER BRAND NAME PRODUCT _____

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

| 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

**Narcotics/APAP**
**Prior Authorization**

**Fax Completed Form to:**
**866-254-0761**
**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 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 | |
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:** | **Diagnosis for this request:** | | |
| **Qualifications for coverage:** | | | |
| □ FAILED THERAPY<br><br>START DATE:<br>END DATE: | DOSE:<br>FREQUENCY: | | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

# Nexiclon Prior Authorization

**Fax Completed Form to:**
**866-254-0761**
**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 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 | |
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br><br>□ **Nexiclon** | **Diagnosis for this request:** | | |
| **Qualifications for coverage:** | | | |
| □ FAILED CLONIDINE THERAPY<br><br>START DATE:<br>END DATE: | DOSE:<br>FREQUENCY: | | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Nitroglycerin Lingual Spray**
**Prior Authorization**

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

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 | |
|---|---|---|---|
| Physician Name: | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **QUALIFICATIONS FOR COVERAGE:** | | | |
| Requested Drug and Dosage:<br>□ **Nitroglycerin Lingual Spray** | | Diagnosis for this request: | |
| Failed Therapy: | | Start Date:<br>End Date: | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

# Nuedexta Prior Authorization

**Fax Completed Form to:**
**866-254-0761**
**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 | |
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ **Nuedexta** | **Diagnosis for this request (must check at least 2):**<br>□ **PBA**<br>□ **ALS** □ **MS** | | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# Nucynta Prior Authorization

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

ND Medicaid requires that patients receiving a new prescription for Nucynta must be unable to tolerate other opioids due to gastrointestinal side effects.

- **Oxycodone 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 Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ **Nucynta** | **Diagnosis for this request:** | | |
| **Qualifications for coverage:** | | | |
| □ UNABLE TO TOLERATE OTHER OPIOIDS DUE TO GASTROINTESTINAL SIDE EFFECTS<br>OPIOID TRIED_____ START DATE: DOSE:<br>END DATE: FREQUENCY: | | | |
| Prescriber 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# OLYSIO PA FORM


Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
| Physician Name | Specialist involved in therapy | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |

| | | | |
|---|---|---|---|
| **Requested Drug**<br>□ **Olysio**<br>Dosage<br>_____ | **Documented liver fibrosis** | **Diagnosis for this request**<br>**Genotype** | **Patient is drug and alcohol free for past 12 months**<br>□ YES □ NO |
| | **Presence of Q80K polymorphism?**<br>□ YES □ NO | **Pegylated interferon dose**<br>**Ribavirin dose** | **Negative pregnancy test in the past 30 days**<br>□ YES □ NO |

| | |
|---|---|
| Has the patient been previously treated for chronic hepatitis C?<br>□ YES □ NO<br>If yes, please indicate past treatment regimen(s), dates of treatment, and response to therapy: | Baseline HCV RNA:<br>HCV RNA 4 weeks after starting therapy: |
| 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Onmel**
**Prior Authorization**

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

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 | |
|---|---|---|---|
| Physician Name: | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **QUALIFICATIONS FOR COVERAGE:** | | | |
| Requested Drug and Dosage:<br>□ **Onmel** | | Diagnosis for this request: | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

**Orally Disintegrating Tablets (ODT)**
**Prior Authorization**

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

Prior Authorization Vendor for ND Medicaid

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 | |
|---|---|---|---|
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:** | **Diagnosis for this request:** | | |
| **Qualifications for coverage:** | | | |
| □ Unable to Swallow<br>□ Medication Failed<br>_____ | Start Date:<br>End Date: | Dose:<br>Frequency: | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

**Ophthalmic Antihistamines**
**Prior Authorization**

**Fax Completed Form to:**
**866-254-0761**
**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 Lastacaft, Bepreve, and Pataday must first try one of the following:

- ***Ketotifen, Azelastine, Elestat, 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 | |
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ **Lastacaft** □ **Bepreve** □ **Pataday** | **Diagnosis for this request:** | | |
| **Qualifications for coverage:** | | | |
| □ FAILED THERAPY<br>START DATE: DOSE:<br>END DATE: FREQUENCY: | | | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# OPHTHALMIC ANTI-INFECTIVE PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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®).**

**Part I: TO BE COMPLETED BY PRESCRIBER**

| | | | |
|---|---|---|---|
| Recipient Name | Recipient Date of Birth | Recipient Medicaid ID Number | |
| Prescriber Name | | | |
| Prescriber Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ AZASITE □ MOXEZA<br>□ QUIXIN | **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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# DORYX and ORACEA PA FORM

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

Prior Authorization Vendor for ND Medicaid

Note: ND Medicaid will not pay for Oracea without documented failure of a first line tetracycline agent.

- First line agents include: doxycycline, minocycline, and tetracycline.

**Part I: TO BE COMPLETED BY PRESCRIBER**

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

| | |
|---|---|
| **REQUESTED DRUG:**<br>□ **ORACEA** □ **DORYX** | **Requested Dosage:** (must be completed) |

**Qualifications for coverage:**

□ Patient has failed a 90 day trial of which first line agent _____

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the 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 -<br>Effective dates of PA: | From: / / | To: / / |
| Denied: (Reasons) | | |

# ORAL ANTICOAGULANTS
# PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

ND Medicaid requires that patients receiving a new prescription for Pradaxa, Xarelto or Eliquis 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 | |
|---|---|---|---|
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ PRADAXA □ XARELTO □ ELIQUIS | **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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

# Oravig Prior Authorization

**Fax Completed Form to:**
**866-254-0761**
**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 Oravig first try fluconazole.
***Note:***

- ***Fluconazole does not require PA***

**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:**<br>□ **Oravig** | **Diagnosis for this request:** | | |
| **Qualifications for coverage:** | | | |
| □ **Medication failed**<br>_____ | **Start Date:**<br>**End Date:** | **Dose:**<br>**Frequency:** | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

# OXYCODONE CR
# PA FORM

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

***Note: The PA may be approved if all of the following criteria are met.**

- **Patient has a chronic pain indication (includes cancer).**
- **Patient has taken an immediate release narcotic for the past 90 days or is switching from another sustained release opioid analgesic.**

**Part I: TO BE COMPLETED BY PRESCRIBER**

| Recipient Name | | Recipient Date of Birth | Recipient Medicaid ID Number | |
|---|---|---|---|---|
| Prescriber Name | | | | |
| Prescriber Medicaid Provider Number | | Telephone Number | Fax Number | |
| Address | | City | State | Zip Code |
| **Requested Drug:**<br>□ OXYCODONE CR | **DOSAGE:** | **Diagnosis for this request:** | | |
| **QUALIFICATIONS FOR COVERAGE:**<br>□ CHRONIC MALIGNANT PAIN INDICATION<br>□ CHRONIC NON-MALIGNANT PAIN INDICATION | | **LIST IMMEDIATE RELEASE MEDICATION TAKEN:** | | |
| **LIST OTHER SUSTAINED RELEASE OPIOID ANALGESIC PATIENT IS SWITCHING FROM:** | | | | |
| □ *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: |
|---|---|---|---|
| TELEPHONE NUMBER | FAX NUMBER | DRUG | NDC # |

**Part III: FOR OFFICIAL USE ONLY**

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

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

# Proton Pump Inhibitor PA Form

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

ND Medicaid requires that patients receiving proton pump inhibitors must use Prilosec OTC, Prevacid 24HR, Omeprazole, or Pantoprazole as first line.

***Note:***

- **Prilosec OTC, Prevacid 24HR, Omeprazole and Pantoprazole may be prescribed WITHOUT prior authorization. Prilosec OTC and Prevacid 24HR are covered by Medicaid when prescribed by a physician.**
- **Patients must use Prilosec OTC, Prevacid 24HR, omeprazole, or pantoprazole for a minimum of 14 days for the trial to be considered a failure. Patient preference does not constitute a failure.**
- **Net cost to Medicaid: Prilosec OTC = Prevacid 24HR = Omeprazole = Pantoprazole <<< Lansoprazole << Aciphex << Nexium << Zegerid <<< Dexilant.**

**Part I: TO BE COMPLETED BY PRESCRIBER**

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

| | |
|---|---|
| **REQUESTED DRUG:**<br>□ Aciphex □ Lansoprazole<br>□ Nexium □ Zegerid □ Dexilant | **Requested Dosage:** (must be completed)<br>**Diagnosis for this request:** |

**Qualifications for coverage:**

| | | |
|---|---|---|
| ❑ Failed Prilosec OTC/Prevacid 24HR/Omeprazole/Pantoprazole therapy | Start Date:<br>End Date: | Dose:<br>Frequency: |
| □ Pregnancy – Due Date | | |
| □ Inability to take or tolerate oral tablets (must check a box)<br>□ Tube Fed<br>□ Requires soft food or liquid administration<br>□ 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 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 -<br>Effective dates of PA: | From: / / | To: / / |
| Denied: (Reasons) | | |

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

# Provigil/Nuvigil Prior Authorization

**Fax Completed Form to:**
**866-254-0761**
**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 Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ **Nuvigil** □ **Provigil** | **Diagnosis for this request:** | | |
| **Qualifications for coverage:** | | | |
| □ FAILED PROVIGIL (Nuvigil Requests) | START DATE:<br>END DATE: | DOSE:<br>FREQUENCY: | |
| □ EXCESSIVE SLEEPINESS ASSOCIATED WITH OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME<br>□ NARCOLEPSY<br>□ SHIFT WORK SLEEP DISORDER | | | |
| Prescriber 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 -<br>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:**
**866-254-0761**
**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**

**Part I: TO BE COMPLETED BY PHYSICIAN**

| Recipient Name | **Recipient Date of Birth** | Recipient Medicaid ID Number | |
|---|---|---|---|
| Physician Name | Specialist Involved in therapy: | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ LETAIRIS □ TRACLEER □ VENTAVIS<br>□ REVATIO □ ADCIRCA □ TYVASO<br>□ OTHER_____ | **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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Pulmozyme**
**Prior Authorization**

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

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 | |
|---|---|---|---|
| Physician Name: | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **QUALIFICATIONS FOR COVERAGE:** | | | |
| Requested Drug and Dosage:<br>□ **Pulmozyme** | | Diagnosis for this request: | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# QUALAQUIN PA FORM

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

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 MEDICAID ID NUMBER: |
| Address: | Phone: ( ) |
| City: | FAX: ( ) |
| State: Zip: | |

| | |
|---|---|
| **REQUESTED DRUG:**<br>□ **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 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 -<br>Effective dates of PA: From: / / | To: / / |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Rayos**
**Prior Authorization**

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

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 | |
|---|---|---|---|
| Physician Name: | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **QUALIFICATIONS FOR COVERAGE:** | | | |
| Requested Drug and Dosage:<br>□ **Rayos** | | Diagnosis for this request: | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# RIBAPAK PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ RIBAPAK | **FDA Approved Indication for this request:** | | |

| | | | |
|---|---|---|---|
| □ **Failed therapy with Ribavirin or Ribasphere** | **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. | | | |
| 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

# Relistor Prior Authorization

**Fax Completed Form to:**
**866-254-0761**
**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

**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 Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ **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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

# Sancuso Prior Authorization

**Fax Completed Form to:**
**866-254-0761**
**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 Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ **Sancuso** | **Diagnosis for this request:** | | |
| **Qualifications for coverage:** | | | |
| □ FAILED MEDICATION | START DATE:<br>END DATE: | DOSE:<br>FREQUENCY: | |
| □ PATIENT UNABLE TO TAKE ORAL MEDICATIONS | | | |
| Prescriber 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

# Sedative/Hypnotic PA Form

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

ND Medicaid requires that patients receiving a new prescription for a name brand Sedative/Hypnotic must use Ambien® (zolpidem) as first line therapy.

***Note:***

- **The PA will be approved if there is a failed trial of Ambien (zolpidem).**
- **Estazolam, flurazepam, temazepam, triazolam, quazepam and Ambien (zolpidem) do not require a PA.**

**Part I: TO BE COMPLETED BY PRESCRIBER**

| Recipient Name | Recipient Date of Birth | Recipient Medicaid ID Number | |
|---|---|---|---|
| Prescriber Name | | | |
| Prescriber Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:** | **Diagnosis for this request:** | | |
| **Qualifications for coverage:** | | | |
| □ FAILED AMBIEN (ZOLPIDEM) | Start Date:<br>End Date: | Dose:<br>Frequency: | |
| □ HIGH RISK FOR ADDICTION | | | |
| □ *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 NUMBER | FAX NUMBER | DRUG | NDC # |

**Part III: FOR OFFICIAL USE ONLY**

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

## Short-Acting HFA Beta$_2$ Agonist PA FORM


Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

ND Medicaid requires that patients receiving a new prescription for ProAir HFA, Ventolin HFA, or Xopenex HFA must use Proventil HFA as first line therapy.

***Note: Proventil HFA does 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 Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ XOPENEX HFA<br>□ VENTOLIN HFA<br>□ PROAIR HFA | **Diagnosis for this request:** | | |

| **Qualifications for coverage:** | | | | |
|---|---|---|---|---|
| □ Failed Proventil HFA 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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# SOVALDI PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
| Physician Name | | Specialist involved in therapy | | |
| Physician Medicaid Provider Number | | Telephone Number | Fax Number | |
| Address | | City | State | Zip Code |
| **Requested Drug**<br>□ **Sovaldi**<br>Dosage<br>_____ | **Documented liver fibrosis** | **Diagnosis for this request**<br>**Genotype**<br>**Pegylated interferon dose**<br>**Ribavirin dose** | **Patient is drug and alcohol free for past 12 months**<br>□ YES □ NO<br>**Negative pregnancy test in the past 30 days**<br>□ YES □ NO | **eGFR** |
| Has the patient been previously treated for chronic hepatitis C?<br>□ YES □ NO<br>If yes, please indicate past treatment regimen(s), dates of treatment, and response to therapy: | | | Baseline HCV RNA:<br>HCV RNA 4 weeks after starting therapy: | |
| 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

**Statins**
**Prior Authorization**

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed a name-brand statin must first try a generic statin.
***Note:***

- ***Generic statins already on the market do not require a prior authorization***

**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:** | **Diagnosis for this request:** | | |
| **Qualifications for coverage:** | | | |
| □ Medication Failed<br>_____ | Start Date:<br>End Date: | Dose:<br>Frequency: | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

# SYNAGIS WEB BASED FORM

**For questions regarding this Prior Authorization Call 701-328-4023**

Prior Authorization Vendor for ND Medicaid

Note:

- Synagis season will be October 19th through April 21st
- Providers will choose when to start dosing Synagis based on prevalence of RSV in the community
- Clinicians may administer up to a maximum of 5 monthly doses during the RSV season.
- Qualifying infants born during the RSV season may require fewer doses.

**TO BE COMPLETED BY PRESCRIBER**

| Recipient Medicaid ID Number | Recipient Date of Birth | Prescriber NPI | Prescriber Fax Number |
|---|---|---|---|
| | | | |

Diagnosis (qualification for Synagis)

___ **Prematurity**

<29 weeks, 0 days gestational age – Synagis allowed if younger than 12 months of age at start of RSV season (max of 5 doses)

**Gestational Age (e.g. 28 weeks, 4 days)**

**Weeks** _____ **Days** _____

___ **Chronic Lung Disease of Prematurity (CLD)** – Child ≤12 months old with gestational age <32 weeks, 0 days and requires supplemental oxygen >21% for at least the first 28 days after birth.

___ **Chronic Lung Disease of Prematurity (CLD**) – Child ≤24 months old with gestational age <32 weeks, 0 days and requires supplemental oxygen >21% for at least the first 28 days after birth and continues to receive medical support within six months before the start of RSV season.

___ Supplemental Oxygen

___ Diuretic

___ Chronic corticosteroid therapy

___ **Congenital Heart Disease (CHD)**

Child ≤12 months old with hemodynamically significant cyanotic or acyanotic CHD

Medical Therapy Required _____

*children less than 24 months who undergo cardiac transplantation during RSV season may be considered for prophylaxis.

___ **Neuromuscular disease** (may be considered for prophylaxis during the first year of life)

___ **Pulmonary abnormalities** (may be considered for prophylaxis during the first year of life)

___ **Profoundly Immunocompromised children** (children <24 months of age may be considered for prophylaxis during the RSV season)

***Accessed online at pediatrics.aappublications.org**

HEALTH INFORMATION DESIGNS

# Tecfidera Prior Authorization

**Fax Completed Form to:**
**866-254-0761**
**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).***

**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:**<br>□ **Tecfidera** | **Diagnosis for this request:**<br>**Current CBC (date):** | | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

## 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.

# TOPICAL ACNE AGENTS
# PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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**
- **Patients must first try and fail a generic topical acne agent (erythromycin, benzoyl peroxide, clindamycin, tretinoin, sodium sulfacetamide/sulfur)**

**Part I: TO BE COMPLETED BY PHYSICIAN**

| | | | |
|---|---|---|---|
| Recipient Name | **Recipient Date of Birth** | Recipient Medicaid ID Number | |
| Physician Name | Dermatologist Involved in therapy (if patient is <10 and >35):<br><br>Next Appointment date: | | |
| Physician Medicaid Provider Number | 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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# LOCAL ANESTHETICS (TOPICAL) PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
|---|---|---|---|
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ EMLA □ SYNERA | **Medical Procedure:** | | |
| 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

**Topical Ketoconazole Products**
**Prior Authorization**

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

Prior Authorization Vendor for ND Medicaid

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 | |
|---|---|---|---|
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ **Extina** □ **Xolegel** □ **Ketocon Plus** | **Diagnosis for this request:** | | |
| **Qualifications for coverage:** | | | |
| □ Medication Failed<br>_____ | Start Date:<br>End Date: | Dose:<br>Frequency: | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# TRAMADOL ER PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

ND Medicaid requires that patients receiving a new prescription for tramadol ER (Ultram ER/Ryzolt) or tramadol ODT (Rybix) must meet the following criteria:

- **Documented failure of a 30-day trial of generic immediate release tramadol at maximum daily dosage of 400mg per day.**

**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:**<br>□ ULTRAM ER OR GENERIC □ RYZOLT □ RYBIX | **Diagnosis for this request:** | | |

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

| | |
|---|---|
| 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# Serotonin (5-$HT_1$) Receptor Agonists - Triptan PA FORM


Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

ND Medicaid requires that patients receiving a new prescription for Axert, Frova, Maxalt, Relpax, Treximet, or Zomig must try sumatriptan then naratriptan as first line therapies.

***Note:**

- **Sumatriptan does not require a PA.**
- **Injectables are not subject to a prior authorization at this time.**

**Part I: TO BE COMPLETED BY PRESCRIBER**

| Recipient Name | Recipient Date of Birth | Recipient Medicaid ID Number | |
|---|---|---|---|
| Prescriber Name | | | |
| Prescriber Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ NARATRIPTAN<br>□ RELPAX □ MAXALT<br>□ AXERT □ TREXIMET<br>□ FROVA □ ZOMIG | **Diagnosis for this request:** | | |

| **Qualifications for coverage:** | | | | |
|---|---|---|---|---|
| □ Failed sumatriptan therapy | Start Date | End Date | Dose | Frequency |
| □ Failed naratriptan 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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# ULORIC PA FORM


Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
|---|---|---|---|
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ 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.* | | | | |
| 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# VANOS PA FORM


Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br><br>□ VANOS | **Diagnosis for this Request:** | | |
| **Failed Therapy (dose and frequency):**<br><br>□ | **Start Date:**<br><br>**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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

**VECAMYL**
**PA FORM**

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
| Physician Name | Specialist Involved in Therapy | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ VECAMYL | **Diagnosis for this Request:** | | |
| **Failed Therapy:** | **Start Date:**<br><br>**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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# Vusion PA FORM


Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 | |
|---|---|---|---|
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ VUSION | **Diagnosis for this request:** | | |

| **Qualifications for coverage:** | | | | |
|---|---|---|---|---|
| □ Failed antifungal therapy<br>Name of medication failed:<br>_____ | 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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Xeljanz**
**Prior Authorization**

**Fax Completed Form to:**
**866-254-0761**
**For questions regarding this Prior authorization, call**
**866-773-0695**

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 | |
|---|---|---|---|
| Physician Name: | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |

**QUALIFICATIONS FOR COVERAGE:**

| Requested Drug and Dosage:<br><br>□ **Xeljanz** | Diagnosis for this request: |
|---|---|
| TB test in the past 6 months □ Yes □ No<br><br>Lab monitoring has occurred and measurements within acceptable limits (i.e., lymphocytes, neutrophils, hemoglobin, lipids, and liver enzymes) □ Yes □ NO<br><br>Has or has had active hepatitis B or C virus □ Yes □ NO | Failed methotrexate therapy<br><br>Start date: End date: |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

# Xenical Prior Authorization

**Fax Completed Form to:**
**866-254-0761**
**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 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 Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br>□ XENICAL | **Diagnosis for this request:** | | |
| **Qualifications for coverage:** | | | |
| □ Dietician evaluation attached | Height: | Weight: | BMI: |
| Prescriber 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# XIFAXAN PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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 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 | |
|---|---|---|---|
| Physician Name | | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **Requested Drug and Dosage:**<br><br>□ XIFAXAN | **Diagnosis for this Request:**<br><br>□ TRAVELER'S DIARRHEA: 200 mg three times a day for 3 days<br><br>□ 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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# XOLAIR PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

**Fax Completed Form to:**
**866-254-0761**
**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**

**Part I: TO BE COMPLETED BY PHYSICIAN**

| | | | |
|---|---|---|---|
| Recipient Name | **Recipient Date of Birth** | Recipient Medicaid ID Number | |
| Physician Name | Specialist Involved in Therapy (if not treating physician) | | |
| Physician Medicaid Provider Number | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |

| | | |
|---|---|---|
| **Requested Drug and Dosage:**<br>□ XOLAIR | **Diagnosis for this Request:** | **Serum IgE Level:** |

| | |
|---|---|
| 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

# Xyrem Prior Authorization

**Fax Completed Form to:**
**866-254-0761**
**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 Success Program***

**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:**<br>□ **Xyrem** | **Diagnosis for this request:** | | |
| **Qualifications for coverage:** | | | |
| □ Enrolled in Xyrem Success Program | Enrolled Date: | Dose: | |
| Physician 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

# Zanaflex Capsule PA Form

**Fax Completed Form to:**
**866-254-0761**
**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 Medicaid Provider Number | 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:<br>End Date: | Dose:<br>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 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 -<br>Effective dates of PA: From: / / To: / / | Approved by: |
| Denied: (Reasons) | |

# NORTH DAKOTA MEDICAID
# RETROSPECTIVE DRUG UTILIZATION REVIEW
# CRITERIA RECOMMENDATIONS
# 4TH QUARTER 2014

***Criteria Recommendations*** ***Approved*** ***Rejected***

**1. Albiglutide / Overutilization** _____ _____

Alert Message: The recommended dosage of Tanzeum (albiglutide) is 30 mg once weekly given as a subcutaneous injection in the abdomen, thigh, or upper arm region. The dosage may be increased to 50 mg once weekly if the glycemic response is inadequate.

Conflict Code: ER - Overutilization
Drugs/Diseases

| Util A | Util B | Util C |
|---|---|---|
| Albiglutide | | |

Max Dose: 50 mg per week

References:
Tanzeum Prescribing Information, April 2014, GlaxoSmithKline.
Clinical Pharmacology, 2014 Elsevier/Gold Standard.

**2. Albiglutide / Insulin and Insulin Secretagogues** _____ _____

Alert Message: The risk of hypoglycemia is increased when Tanzeum (albiglutide) is used in combination with insulin secretagogues (e.g. sulfonylureas) or insulin. Therefore, patients may require a lower dose of sulfonylurea or insulin to reduce the risk of hypoglycemia in this setting.

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

| Util A | Util B | Util C |
|---|---|---|
| Albiglutide | Insulins | |
| | Chlorpropamide | |
| | Glimepiride | |
| | Glipizide | |
| | Glyburide | |
| | Tolazamide | |
| | Tolbutamide | |

References:
Tanzeum Prescribing Information, April 2014, GlaxoSmithKline.
Clinical Pharmacology, 2014 Elsevier/Gold Standard.

**3. Albiglutide / Non-adherence** _____ _____

Alert Message: Non-adherence to Tanzeum (albiglutide) therapy may result in loss of glycemic control and an increased risk of developing adverse diabetic-related complications.

Conflict Code: LR – Non-adherence
Drugs/Diseases

| Util A | Util B | Util C |
|---|---|---|
| Albiglutide | | |

References:
Tanzeum Prescribing Information, April 2014, GlaxoSmithKline.
Currie CJ, Peyrot M, Morgan CL, et al. The Impact of Treatment Noncompliance on Mortality in People With Type 2 Diabetes. Diabetes Care 35:1279-1284, June 2012.
Butler RJ, Davis TK, Johnson WL, et al. Effects of Nonadherence with Prescription Drugs Among Older Adults. Am J Manag Care. 2011 Feb; 17(2):153-60.

**4. Albiglutide / Thyroid Carcinoma & MENS II** _____ _____

Alert Message: The use of Tanzeum (albiglutide), a glucagon-like peptide-1 (GLP-1) receptor agonist, is contraindicated in patients with a personal or family history of medullary thyroid carcinoma (MTC) or with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2). GLP-1 receptor agonists have been shown to increase the incidence of thyroid C-cell tumors in rodents. Counsel patients regarding the risk of MTC and the symptoms of thyroid tumors (e.g. a mass in the neck, dysphagia, dyspnea or persistent hoarseness).

Conflict Code: TA - Therapeutic Appropriateness – Contraindication (Black Box Warning)
Drugs/Diseases

| Util A | Util B | Util C **(Included)** |
|---|---|---|
| Albiglutide | | Medullary Thyroid Carcinoma II |
| | | Thyroid Carcinoma |
| | | History of Thyroid Carcinoma |

References:
Tanzeum Prescribing Information, April 2014, GlaxoSmithKline.
Clinical Pharmacology, 2014 Elsevier/Gold Standard.

**5. Albiglutide / Therapeutic Appropriateness** _____ _____

Alert Message: Tanzeum (albiglutide) is a glucagon-like peptide-1 (GLP-1) receptor agonist and GLP-1 agonists have been shown to cause thyroid C-cell tumors at clinically relevant exposure in rodents. It is unknown whether albiglutide causes thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans. Counsel patients regarding the risk of medullary thyroid carcinoma and the symptoms of thyroid tumors (e.g., a mass in the neck, dysphagia, dyspnea or persistent hoarseness).

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

| Util A | Util B | Util C **(Negate)** |
|---|---|---|
| Albiglutide | | Medullary Thyroid Carcinoma II |
| | | Thyroid Carcinoma |
| | | History of Thyroid Carcinoma |

References:
Tanzeum Prescribing Information, April 2014, GlaxoSmithKline.
Clinical Pharmacology, 2014 Elsevier/Gold Standard.

**6. Albiglutide / Pancreatitis** _____ _____

Alert Message: In clinical trials, acute pancreatitis has been reported in association with Tanzeum (albiglutide) use. Albiglutide should be promptly discontinued if pancreatitis is suspected and should not be restarted if confirmed. Albiglutide has not been studied in patients with a history of pancreatitis to determine whether these patients are at increased risk for pancreatitis. Consider other antidiabetic therapies in patients with a history of pancreatitis.

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

| Util A | Util B | Util C |
|---|---|---|
| Albiglutide | Pancreatitis | |

References:
Tanzeum Prescribing Information, April 2014, GlaxoSmithKline.
Clinical Pharmacology, 2014 Elsevier/Gold Standard.

**7. Albiglutide / Therapeutic Appropriateness** _____ _____

Alert Message: Safety and effectiveness of Tanzeum (albiglutide) have not been established in pediatric patients.

Conflict Code: TA – Therapeutic Appropriateness

Drugs/Diseases

| Util A | Util B | Util C |
|---|---|---|
| Albiglutide | | |

Age Range: 0-18 yoa

References:

Tanzeum Prescribing Information, April 2014, GlaxoSmithKline.

Clinical Pharmacology, 2014 Elsevier/Gold Standard.

**8. Albiglutide / Pregnancy / Delivery, Miscarriage & Abortion** _____ _____

Alert Message: There are no adequate and well-controlled studies of Tanzeum (albiglutide) in pregnant women. Nonclinical studies have shown reproductive toxicity, but not teratogenicity, in mice. Albiglutide is Pregnancy Category C and should not be used during pregnancy unless the expected benefit outweighs the potential risks.

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

Drugs/Diseases

| Util A | Util B | Util C **(Negating)** |
|---|---|---|
| Albiglutide | Pregnancy | Delivery |
| | | Miscarriage |
| | | Abortion |

References:

Tanzeum Prescribing Information, April 2014, GlaxoSmithKline.

Clinical Pharmacology, 2014 Elsevier/Gold Standard.

**9. Albiglutide / Renal Impairment** _____ _____

Alert Message: Use caution when initiating or escalating doses of Tanzeum (albiglutide) in patients with renal impairment. In a trial of albiglutide in patients with renal impairment, the frequency of gastrointestinal events increased as renal function declined. No dosage adjustment is recommended in renal impairment but monitoring renal function is recommended in patients reporting severe adverse gastrointestinal reactions.

Conflict Code: TA – Therapeutic Appropriateness

Drugs/Diseases

| Util A | Util B | Util C **(Include)** |
|---|---|---|
| Albiglutide | | Renal Impairment |

References:

Tanzeum Prescribing Information, April 2014, GlaxoSmithKline.

Clinical Pharmacology, 2014 Elsevier/Gold Standard.

**10. Albiglutide / Severe Gastrointestinal Disorders** _____ _____

Alert Message: Tanzeum (albiglutide), a glucagon-like peptide-1 (GLP-1) receptor agonist, has not been studied in patient with pre-existing severe gastrointestinal disease, including severe gastroparesis. Its use is not recommended in patients with severe GI disease. GLP-1 receptor agonists slow gastric emptying and can exacerbate gastrointestinal disorders.

Conflict Code: TA – Therapeutic Appropriateness

Drugs/Diseases

| Util A | Util B | Util C **(Include)** |
|---|---|---|
| Albiglutide | | Gastroparesis |
| | | Irritable Bowel Syndrome |
| | | Diverticular Disease |
| | | Crohn's Disease |
| | | Ulcerative Colitis |

References:

Tanzeum Prescribing Information, April 2014, GlaxoSmithKline.

Clinical Pharmacology, 2014 Elsevier/Gold Standard.

**11. Linagliptin-All / Therapeutic Appropriateness** _____ _____

Alert Message: There have been post-marketing reports of acute pancreatitis including fatal pancreatitis, in patients taking linagliptin. If pancreatitis is suspected, promptly discontinue the linagliptin-containing product and initiate appropriate management. It is unknown whether patients with a history of pancreatitis are at increased risk while using linagliptin.

Conflict Code: TA - Therapeutic Appropriateness

Drugs/Diseases

| Util A | Util B | Util C |
|---|---|---|
| Linagliptin | | |

References:

Tradjenta Prescribing Information, June 2013, Boehringer Ingelheim Pharmaceuticals. Inc.

Jentadueto Prescribing Information, June 2013, Boehringer Ingelheim Pharmaceuticals. Inc.

**12. Viscous Lidocaine 2% / Black Box Warning** _____ _____

Alert Message: Oral viscous lidocaine 2% solution should not be used to treat infants and children with teething pain. This agent is not approved to treat teething pain and its use in infants and young children can cause serious harm, including death.

Conflict Code: TA – Therapeutic Appropriateness

Drugs/Diseases

| Util A | Util B | Util C **(Negating)** |
|---|---|---|
| Viscous Lidocaine 2% | | Neoplasm |
| | | Chemotherapy |

Age Range: 0 – 4 yoa

References:

MedWatch The FDA Safety Information and Adverse Event Reporting Program - Lidocaine Viscous: Drug Safety Communication – Boxed Warning Required – Should Not Be Used to Treat Teething Pain. [6/26/2014].

**13. Empagliflozin / Overutilization** _____ _____

Alert Message: Jardiance (empagliflozin) may be over-utilized. The manufacturer's recommended dose of empagliflozin is 10 mg once daily in the morning, taken with or without food. In patients tolerating empagliflozin, the dose may be increased to 25 mg once daily.

Conflict Code: ER - Overutilization

Drugs/Diseases

| Util A | Util B | Util C |
|---|---|---|
| Empagliflozin | | |

Max Dose: 25mg/day

References:

Jardiance Prescribing Information, Aug. 2014, Boehringer Ingelheim Pharmaceuticals, Inc.

**14. Empagliflozin / Mild to Moderate Renal Impairment** _____ _____

Alert Message: Assessment of renal function is recommended prior to initiation of Jardiance (empagliflozin) and periodically thereafter. No dosage adjustment is needed in patients with an eGFR greater than or equal to 45 mL/min/1.73m2. Empagliflozin should not be initiated in patients with an eGFR less than 45 mL/min/1.73m2 and should be discontinued if eGFR is persistently less than 45 mL/min/1.73m2.

Conflict Code: TA – Therapeutic Appropriateness

Drugs/Diseases

| Util A | Util B | Util C **(Include)** |
|---|---|---|
| Empagliflozin | | CKD Stage 1 |
| | | CKD Stage 2 |
| | | CKD Stage 3 |

References:

Jardiance Prescribing Information, Aug. 2014, Boehringer Ingelheim Pharmaceuticals, Inc.

**15. Empagliflozin / Severe Renal Impairment, ESRD & Dialysis** _____ _____

Alert Message: Jardiance (empagliflozin) use is contraindicated in patients with severe renal impairment, end-stage renal disease, or receiving dialysis. Based on its mechanism of action, inhibition of SGLT2 in the proximal renal tubules, empagliflozin is not expected to be effective in these patients.

Conflict Code: TA – Therapeutic Appropriateness

Drugs/Diseases

| Util A | Util B | Util C **(Include)** |
|---|---|---|
| Empagliflozin | | ESRD |
| | | CKD Stage 4 & 5 |
| | | Dialysis |

References:

Jardiance Prescribing Information, Aug. 2014, Boehringer Ingelheim Pharmaceuticals, Inc.

**16. Empagliflozin / Non-adherence** _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Jardiance (empagliflozin). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Conflict Code: LR – Non-adherence
Drugs/Diseases

| Util A | Util B | Util C |
|---|---|---|
| Empagliflozin | | |

References:
Jardiance Prescribing Information, Aug. 2014, Boehringer Ingelheim Pharmaceuticals, Inc.
Osterberg L, Blaschke T. Adherence to medication. N Engl J Med 2005;353:487-97.
Ho PM, Rumsfeld JS, Masoudi FA, et al., Effect of Medication Nonadherence in Diabetes Mellitus. Cardiology Review, April 2007.
Currie CJ, Peyrot M, Morgan CL, et al. The Impact of Treatment Noncompliance on Mortality in People With Type 2 Diabetes. Diabetes Care 35:1279-1284, June 2012.
Butler RJ, Davis TK, Johnson WL, et al. Effects of Nonadherence with\Prescription Drugs Among Older Adults. Am J Manag Care. 2011 Feb; 17(2):153-60.

**17. Empagliflozin / Hypotension, Hypovolemia CKD Stage 3 & Dehydration** _____ _____

Alert Message: Jardiance (empagliflozin) causes osmotic diuresis which can lead to volume depletion and hypotension, particularly in patients with impaired renal function, elderly patients, or patients on diuretics. Monitor patients for signs and symptoms during therapy. Before initiating empagliflozin in patients with one or more of these characteristics, volume status should be assessed and corrected.

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

| Util A | Util B | Util C |
|---|---|---|
| Empagliflozin | Hypotension | |
| | Hypovolemia | |
| | CKD Stage 3 | |
| | Dehydration | |

References:
Jardiance Prescribing Information, Aug. 2014, Boehringer Ingelheim Pharmaceuticals, Inc.

**18. Empagliflozin / Diuretics** _____ _____

Alert Message: Jardiance (empagliflozin) causes osmotic diuresis which can lead to volume depletion and hypotension, particularly in patients with impaired renal function, elderly patients or patients on diuretics. Monitor patients for signs and symptoms during therapy. Before initiating empagliflozin in patients with one or more of these characteristics, volume status should be assessed and corrected.

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

| Util A | Util B | Util C |
|---|---|---|
| Empagliflozin | Loop Diuretics | |
| | Thiazide Diuretics | |
| | Potassium Sparing Diuretics | |

References:
Jardiance Prescribing Information, Aug. 2014, Boehringer Ingelheim Pharmaceuticals, Inc.

**19. Empagliflozin / Insulin & Sulfonylureas** _____ _____

Alert Message: The concurrent use of Jardiance (empagliflozin) with insulin or an insulin secretagogue can increase the risk of hypoglycemia. A lower dose of insulin or insulin secretagogue may be required to minimize the risk of hypoglycemia when used in combination with empagliflozin.

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

| Util A | Util B | Util C |
|---|---|---|
| Empagliflozin | Insulin | |
| | Chlorpropamide | |
| | Glimepiride | |
| | Glipizide | |
| | Glyburide | |
| | Tolazamide | |
| | Tolbutamide | |

References:
Jardiance Prescribing Information, Aug. 2014, Boehringer Ingelheim Pharmaceuticals, Inc.

**20. Empagliflozin / LDL-Increases** _____ _____

Alert Message: The use of Jardiance (empagliflozin) can cause dose-related increases in LDL-C levels. Patients receiving empagliflozin should have their LDL-C levels monitored and treated per standard of care.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

| Util A | Util B | Util C **(Include)** |
|---|---|---|
| Empagliflozin | | Hypercholesterolemia |

References:
Jardiance Prescribing Information, Aug. 2014, Boehringer Ingelheim Pharmaceuticals, Inc.

**21. Empagliflozin / Pediatric Use** _____ _____

Alert Message: The safety and effectiveness of Jardiance (empagliflozin) in pediatric patients under 18 years of age have not been established.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

| Util A | Util B | Util C |
|---|---|---|
| Empagliflozin | | |

Age Range: 0-17 yoa

References:
Jardiance Prescribing Information, Aug. 2014, Boehringer Ingelheim Pharmaceuticals, Inc.

**22. Canagliflozin/Metformin / Overutilization** _____ _____

Alert Message: Invokamet (canagliflozin/metformin) may be over-utilized. The manufacturer's recommended total daily dose of canagliflozin/metforming is 300mg/2000mg in patients with an eGFR of 60 mL/min/1.73m2 or greater.

Conflict Code: ER - Overutilization
Drugs/Diseases

| Util A | Util B | **Util C (Negating)** |
|---|---|---|
| Canagliflozin/Metformin | | CKD Stage 3, 4 & 5 |
| | | ESRD |
| | | Dialysis |

Max Dose: 300mg/2000mg per day

References:
Invokamet Prescribing Information, Aug. 2014, Janssen Pharmaceuticals, Inc.
Clinical Pharmacology, 2014 Elsevier/Gold Standard.

**23. Canagliflozin/Metformin / Moderate Renal Impairment** _____ _____

Alert Message: The dose of Invokamet (canagliflozin/metformin) should be limited to canagliflozin 50 mg twice daily in patients with moderate renal impairment with an eGFR of 45 to less than 60 mL/min/1.723m2.

Conflict Code: ER - Overutilization
Drugs/Diseases

| Util A | Util B | Util C **(Include)** |
|---|---|---|
| Canagliflozin/Metformin | | CKD Stage 3 |

Max Dose: 100mg/2000mg per day

References:
Invokamet Prescribing Information, Aug. 2014, Janssen Pharmaceuticals, Inc.
Clinical Pharmacology, 2014 Elsevier/Gold Standard.

**24. Canagliflozin/Metformin / Severe Renal Impairment, ESRD & Dialysis** _____ _____

Alert Message: Invokamet (canagliflozin/metformin) is contraindicated in patients with renal impairment (e.g., serum creatinine levels greater than or equal to 1.5mg/dL for males or 1.4 mg/dL for females, or eGFR less than 45 mL/min/1.73 m2), end stage renal disease or patients on dialysis.

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

| Util A | Util B | Util C |
|---|---|---|
| Canagliflozin/Metformin | CKD Stage 4 & 5 | |
| | ESRD | |
| | Dialysis | |

References:
Invokamet Prescribing Information, Aug. 2014, Janssen Pharmaceuticals, Inc.
Clinical Pharmacology, 2014 Elsevier/Gold Standard.

**25. Canagliflozin/Metformin 50mg / UGT Inducers** _____ _____

Alert Message: Concurrent use of Invokamet (canagliflozin/metformin) with a UGT inducer may result in decreased canagliflozin exposure and loss of efficacy. Consider increasing the canagliflozin dose to 150 mg twice daily in patients currently taking 50 mg twice daily who have an eGFR of 60 mL/min/1.73m2 or greater and require additional glycemic control. Consider another antihyperglycemic agent in patients with an eGFR of 45 to less than 60 mL/min/1.73m2 receiving concurrent therapy with a UGT inducer.

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

| Util A | Util B | Util C |
|---|---|---|
| Canagliflozin/Metformin 50mg/500mg | Rifampin | |
| Canagliflozin/Metformin 50mg/1000mg | Phenytoin | |
| | Phenobarbital | |
| | Ritonavir | |

References:
Invokamet Prescribing Information, Aug. 2014, Janssen Pharmaceuticals, Inc.
Clinical Pharmacology, 2014 Elsevier/Gold Standard.

**26. Canagliflozin/Metformin 150mg / UGT Inducers** _____ _____

Alert Message: Concurrent use of Invokamet (canagliflozin/metformin) with a UGT inducer may result in decreased canagliflozin exposure and loss of efficacy. Monitor patient for loss of canagliflozin effectiveness.

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

| Util A | Util B | Util C |
|---|---|---|
| Canagliflozin/Metformin 150mg/500mg | Rifampin | |
| Canagliflozin/Metformin 150mg/1000mg | Phenytoin | |
| | Phenobarbital | |
| | Ritonavir | |

References:
Invokamet Prescribing Information, Aug. 2014, Janssen Pharmaceuticals, Inc.
Clinical Pharmacology, 2014 Elsevier/Gold Standard.

**27. Canagliflozin/Metformin / Therapeutic Appropriateness** _____ _____

Alert Message: Safety and effectiveness of Invokamet (canagliflozin/metformin) in pediatric patients less than 18 years of age have not been established.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

| Util A | Util B | Util C |
|---|---|---|
| Canagliflozin/Metformin | | |

Age Range: 0-17 yoa

References:
Invokamet Prescribing Information, Aug. 2014, Janssen Pharmaceuticals, Inc.
Clinical Pharmacology, 2014 Elsevier/Gold Standard.

**28. Canagliflozin/Metformin / Nonadherence** _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Invokamet (canagliflozin/metformin). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Conflict Code: LR - Nonadherence
Drugs/Diseases

| Util A | Util B | Util C |
|---|---|---|
| Canagliflozin/Metformin | | |

References:
Osterberg L, Blaschke T. Adherence to medication. N Engl J Med 2005;353:487-97.
Miller KE, Medication Nonadherence Affects Diabetes Treatment. Am Family Phys. Vol. 75 No. 6, March 15, 2007.
Ho PM, Rumsfeld JS, Masoudi FA, et al., Effect of Medication Nonadherence in Diabetes Mellitus. Cardiology Review, April 2007.
Currie CJ, Peyrot M, Morgan CL, et al. The Impact of Treatment Noncompliance on Mortality in People With Type 2 Diabetes. Diabetes Care 35:1279-1284, June 2012.
Invokamet Prescribing Information, Aug. 2014, Janssen Pharmaceuticals, Inc.

**29. Canagliflozin/Metformin / Pregnancy / Miscarriage, Delivery & Abortion** _____ _____

Alert Message: Invokamet (canagliflozin/metformin) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Canagliflozin/metformin is classified pregnancy category C.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

| Util A | Util B | Util C **(Negating)** |
|---|---|---|
| Canagliflozin/Metformin | Pregnancy | Delivery<br>Miscarriage<br>Abortion |

Age Range: 11-50 yoa
Gender: Female

References:
Invokamet Prescribing Information, Aug. 2014, Janssen Pharmaceuticals, Inc.
Clinical Pharmacology, 2014 Elsevier/Gold Standard.

**30. Canagliflozin/Metformin / Digoxin** _____ _____

Alert Message: Caution is warranted and monitoring is recommended when Invokamet (canagliflozin/metformin) is coadministered with digoxin. Concurrent use of canagliflozin and digoxin has been shown to increase digoxin exposure. Metformin and digoxin are both cationic drugs and may compete for renal tubular transport resulting in elevated metformin levels.

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

| Util A | Util B | Util C |
|---|---|---|
| Canagliflozin/Metformin | Digoxin | |

References:
Invokamet Prescribing Information, Aug. 2014, Janssen Pharmaceuticals, Inc.
Micromedex Healthcare Series, DrugDex Drug Evaluations, 2014 Truven health Analytics.

**31. Triumeq / Non-adherence** _____ _____

Alert Message: Nonadherence to antiretroviral therapy may result in insufficient plasma levels and partial suppression of viral load leading to the development of resistance, HIV progression, and increased mortality.

Conflict Code: LR – Non-adherence
Drugs/Diseases
Util A Util B Util C
Abacavir/dolutegravir/lamivudine

References:
Hoffman C, Mulcahy F, Goals and Principles of Therapy - Eradication, Cost, Prevention and Adherence. Hoffman C, Rockstroh J, Kamps BS, eds. HIV Medicine, Flying Publishers-Paris, Cagliari, Wuppertal, Sevilla, 2005:167-173.
Cheever LW, Chapter V: Adherence to HIV Therapies. In: A Guide to Clinical Care of Women with HIV/AIDS, 2005 Edition, HIV/AIDS Bureau, US Department of Health and Human Services. http://hab.hrsa.gov/publications/womencare05/WG05chap5.htm
Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents. Department of Health and Human Services. May 1, 2014. Available at: http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf.

**32. Omalizumab / Therapeutic Appropriateness** _____ _____

Alert Message: A 5-year FDA safety review of Xolair (omalizumab) use found a potential for increased risk of serious cardiovascular and cerebrovascular events including, heart attacks, TIA, pulmonary hypertension and pulmonary embolism/venous thrombosis. Patients should be periodically reassessed for the need for continued therapy with omalizumab.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases
Util A Util B Util C
Omalizumab

References:
Xolair Prescribing Information, September 2014, Genentech.
MedWatch: The FDA Safety Information and Adverse Event Reporting Program. Xolair (omalizumab): Drug Safety Communication – Slightly Elevated Risk of Cardiovascular and Cerebrovascular Serious Adverse Events. [09/26/2014].

**33. Indacaterol / Overutilization** _____ _____

Alert Message: The manufacturer's recommended maximum daily dose of Arcapta (indacaterol) is 75 mcg inhaled once daily. Excessive use of indacaterol, or use in conjunction with other medications containing a beta-2-agonist can result in clinically significant cardiovascular effects and may be fatal.

Conflict Code: ER - Overutilization
Drugs/Diseases
Util A Util B Util C
Indacaterol

Max Dose: 75mcg/day

References:
Arcapta Prescribing Information, Sept. 2012, Novartis Pharmaceuticals Corp.
Clinical Pharmacology, 2014 Gold Standard.

**34. Long-Acting Beta-2-Agonists / Therapeutic Duplication** _____ _____

Alert Message: Therapeutic duplication of long-acting beta agonists may be occurring. Clinically significant cardiovascular effects and fatalities have been reported in association with excessive use of inhaled sympathomimetic drugs.

Conflict Code: TD – Therapeutic Duplication
Drugs/Diseases

| Util A | Util B | Util C |
|---|---|---|
| Indacaterol | | |
| Arformoterol | | |
| Formoterol | | |
| Levalbuterol | | |
| Salmeterol | | |
| Olodaterol | | |

References:
Arcapta Prescribing Information, Sept. 2012, Novartis Pharmaceuticals Corp.
Striverdi Respimat Prescribing Information, July 2014, Boehringer Ingelheim Pharmaceuticals. Inc.
Clinical Pharmacology, 2014 Gold Standard.
Facts & Comparisons, 2014 Updates, Wolters Kluwer Health.

**35. Indacaterol / Adrenergic Drugs** _____ _____

Alert Message: Caution should be exercised when Arcapta (indacaterol) is prescribed concurrently with other adrenergic sympathomimetic agents, administered by any route, because the sympathetic effects of indacaterol may be potentiated.

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

| Util A | Util B | | | | Util C |
|---|---|---|---|---|---|
| Indacaterol | Ephedrine | Methyldopa | Phentermine | Naphazoline | |
| | Epinephrine | Tizanidine | Benzphetamine | Pirbuterol | |
| | Pseudoephedrine | Amphetamine | Diethylpropion | Metaproterenol | |
| | Phenylephrine | Dextroamphetamine | Phendimetrazine | Terbutaline | |
| | Clonidine | Lisdexamfetamine | Apraclonidine | | |
| | Guanfacine | Methylphenidate | Brimonidine | | |

References:
Arcapta Prescribing Information, Sept. 2012, Novartis Pharmaceuticals Corp.
Clinical Pharmacology, 2014 Gold Standard.
Facts & Comparisons, 2014 Updates, Wolters Kluwer Health.

**36. Indacaterol / Xanthines Derivatives, Steroids & Diuretics** _____ _____

Alert Message: Caution should be exercised when Arcapta (indacaterol) is prescribed concurrently with xanthine derivatives, steroids, or diuretics because concomitant administration may potentiate the hypokalemic effect of indacaterol. The ECG changes or hypokalemia that may result from the administration of non-potassium sparing diuretics can be acutely worsened by beta-agonists.

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

| Util A | Util B | | Util C |
|---|---|---|---|
| Indacaterol | Theophylline | Dexamethasone | |
| | Aminophylline | Hydrocortisone | |
| | Dyphylline | Methylprednisolone | |
| | Betamethasone | Prednisolone | |
| | Budesonide | Prednisone | |
| | Cortisone | | |

References:
Arcapta Prescribing Information, Sept. 2012, Novartis Pharmaceuticals Corp.
Clinical Pharmacology, 2014 Gold Standard.
Facts & Comparisons, 2014 Updates, Wolters Kluwer Health.

**37. Indacaterol / Non-Potassium Sparing Diuretics** _____ _____

Alert Message: Caution should be exercised when Arcapta (indacaterol) is prescribed concurrently with non-potassium sparing diuretics because concomitant administration may potentiate the ECG changes or hypokalemia that may result\from the administration of the diuretic.

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

| Util A | Util B | Util C |
|---|---|---|
| Indacaterol | Chlorothiazide | |
| | Chlorthalidone | |
| | HCTZ | |
| | Indapamide | |
| | Methyclothiazide | |
| | Metolazone | |
| | Furosemide | |
| | Bumetanide | |
| | Torsemide | |

References:
Arcapta Prescribing Information, Sept. 2012, Novartis Pharmaceuticals Corp.
Clinical Pharmacology, 2014 Gold Standard.
Facts & Comparisons, 2014 Updates, Wolters Kluwer Health.

**38. Indacaterol / Nonselective Beta Blockers** _____ _____

Alert Message: Concurrent use of Arcapta (indacaterol) with a beta-adrenergic receptor antagonist may interfere with the effect of each other. Beta-blockers not only block the therapeutic effects of beta-agonists, but may produce severe bronchospasm in patients with asthma and COPD. If concomitant therapy cannot be avoided, consider a cardioselective beta-blocker, but administered with caution.

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

| Util A | Util B | Util C **(Negating)** |
|---|---|---|
| Indacaterol | Carvedilol | Acebutolol |
| | Nadolol | Atenolol |
| | Labetalol | Betaxolol |
| | Penbutolol | Bisoprolol |
| | Pindolol | Metoprolol |
| | Propranolol | Nebivolol |
| | Sotalol | |
| | Timolol | |

References:
Arcapta Prescribing Information, Sept. 2012, Novartis Pharmaceuticals Corp.
Clinical Pharmacology, 2014 Gold Standard.
Facts & Comparisons, 2014 Updates, Wolters Kluwer Health.

**39. Indacaterol / Cardiovascular, Convulsive Disorders, Thyrotoxicosis & Diabetes** _____ _____

Alert Message: Arcapta (indacaterol) should be used with caution in patients with cardiovascular or convulsive disorders, thyrotoxicosis or sensitivity to sympathomimetic drugs. Indacaterol is a sympathomimetic amine and can aggravate these conditions.

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

| Util A | Util B | Util C |
|---|---|---|
| Indacaterol | Arrhythmia | |
| | Hypertension | |
| | Heart Failure | |
| | Epilepsy | |
| | Seizures | |
| | Diabetes | |

References:
Arcapta Prescribing Information, Sept. 2012, Novartis Pharmaceuticals Corp.
Clinical Pharmacology, 2014 Gold Standard.
Facts & Comparisons, 2014 Updates, Wolters Kluwer Health.

**40. Indacaterol / MAOIs, TCAs & QT Prolongation Agents** _____ _____

Alert Message: Arcapta (indacaterol) should be administered with extreme caution to patients being treated with MAOIs, TCAs, or drugs know to prolong the QTc interval because the action of the adrenergic agonist, indacaterol, on the cardiovascular system may be potentiated by these agents.

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

| Util A | Util B | | | | | Util C |
|---|---|---|---|---|---|---|
| Indacaterol | Albuterol | Disopyramide | Imipramine | Pazopanib | Thioridazine | |
| | Alfuzosin | Dofetilide | Indapamide | Pentamidine | Tizanidine | |
| | Amantadine | Dolasetron | Isradipine | Pimozide | Tolterodine | |
| | Amiodarone | Doxepin | Itraconazole | Posaconazole | Trazodone | |
| | Amitriptyline | Dronedarone | Ketoconazole | Procainamide | TMP/SMZ | |
| | Amphetamine | Droperidol | Lapatinib | Propafenone | Trimipramine | |
| | Arsenic Trioxide | Ephedrine | Levalbuterol | Protriptyline | Vandetanib | |
| | Asenapine | Epinephrine | Levofloxacin | Quetiapine | Vardenafil | |
| | Atazanavir | Erythromycin | Lithium | Quinidine | Venlafaxine | |
| | Atomoxetine | Escitalopram | Metaproterenol | Ranolazine | Ziprasidone | |
| | Azithromycin | Felbamate | Methadone | Risperidone | Zolmitriptan | |
| | Chloral Hydrate | Flecainide | Moexipril/HCTZ | Ritonavir | Ezogabine | |
| | Chloroquine | Fluconazole | Moxifloxacin | Salmeterol | Isocarboxazid | |
| | Chlorpromazine | Fluoxetine | Nicardipine | Saquinavir | Phenelzine | |
| | Ciprofloxacin | Foscarnet | Nilotinib | Sertraline | Tranylcypromine | |
| | Citalopram | Fosphenytoin | Norfloxacin | Solifenacin | Linezolid | |
| | Clarithromycin | Galantamine | Nortriptyline | Sotalol | Rasagiline | |
| | Clomipramine | Gemifloxacin | Octreotide | Sunitinib | | |
| | Clozapine | Granisetron | Ofloxacin | Tacrolimus | | |
| | Dasatinib | Haloperidol | Ondansetron | Tamoxifen | | |
| | Desipramine | Ibutilide | Paliperidone | Telithromycin | | |
| | Diphenhydramine | Iloperidone | Paroxetine | Terbutaline | | |

References:
Arcapta Prescribing Information, Sept. 2012, Novartis Pharmaceuticals Corp.
Clinical Pharmacology, 2014 Gold Standard.
Facts & Comparisons, 2014 Updates, Wolters Kluwer Health.

**41. Indacaterol / Therapeutic Appropriateness** _____ _____

Alert Message: The safety and effectiveness of Arcapta (indacaterol) have not been established in children .

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases
Util A Util B Util C
Indacaterol

Age Range: 0-18 yoa

References:
Arcapta Prescribing Information, Sept. 2012, Novartis Pharmaceuticals Corp.
Clinical Pharmacology, 2014 Gold Standard.
Facts & Comparisons, 2014 Updates, Wolters Kluwer Health.

**42. Indacaterol / Therapeutic Appropriateness (Black Box Warning)** _____ _____

Alert Message: Arcapta (indacaterol) is a long-acting beta-2-adrenergic agonist (LABA) and all LABAs increase the risk of asthma-related death. The safety and efficacy of indacaterol in patients with asthma have not been established. Indacaterol is not indicated for the treatment of asthma.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases
Util A Util B Util C
Indacaterol

References:
Arcapta Prescribing Information, Sept. 2012, Novartis Pharmaceuticals Corp.
Clinical Pharmacology, 2014 Gold Standard.
Facts & Comparisons, 2014 Updates, Wolters Kluwer Health.

**43. Indacaterol / Non-adherence** _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Arcapta (indacaterol). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased outcomes and additional healthcare costs.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases
Util A Util B Util C
Indacaterol

References:
van Boven JF, Chavannes NH, van der Molen T, et al. Clinical and Economic Impact of Non-adherence in COPD: A Systematic Review. Respir Med. 2014 Jan;108(1):103-113.
Restrepo RD, Alvarez MT, Wittnebel LD, et al., Medication Adherence Issues in Patients Treated for COPD. International Journal of COPD. 2008;3(3):371-384.
Simoni-Wastila L, Wei Y, Qian J, et al., Association of Chronic Obstructive Pulmonary Disease Maintenance Medication Adherence With All-Cause Hospitalization and Spending in a Medicare Population. Am Jrnl Geriatr Pharmacother. 2012 Jun;10(3):201-210.
Lareau Sc, Yawn BP. Improving Adherence with Inhaler Therapy in COPD. International Journal COPD. 2010 Nov 24;5:401-406.