DUR Board Meeting
December 3, 2012
Minervas (Kelly Inn)
1800 North 12th Street
Bismarck, ND

North Dakota Medicaid
DUR Board Meeting Agenda
Minervas (Kelly Inn)
1800 North 12th Street
Bismarck, ND
December 3, 2012
1pm

1. Administrative items
    - Travel vouchers

2. Old business

• Review and approval of minutes of 09/12 meeting	Chair
• Budget update	Brendan
• Second review of Actinic Keratosis	Brendan
• Second review of Moxeza	Brendan
• Second review of Patients Taking Multiple Long-Acting Narcotics	Brendan
• Yearly PA review (all)	HID

3. New business

• Genitourinary Smooth Muscle Relaxants	HID
• Agents used to treat Multiple Sclerosis	HID
• Criteria recommendations	HID
• Upcoming meeting date/agenda	Chair

4. Adjourn — Chair

Please remember to silence all cellular phones and pagers during the meeting.

Drug Utilization Review (DUR) Meeting Minutes
September 17, 2012

Members Present: Norman Byers, John Savageau, Russ Sobotta, Todd Twogood, Tanya Schmidt, Carrie Sorenson, Leann Ness, David Clinkenbeard, Jeffrey Hostetter

Members Absent: Kim Krohn, James Carlson, Cheryl Huber, Greg Pfister, Carlotta McCleary, Steve Irsfeld

Medicaid Pharmacy Department: Brendan Joyce

HID Staff Present: Candace Rieth

D. Clinkenbeard called the meeting to order at 1:00 pm. D. Clinkenbeard asked for a motion to approve the minutes from the June meeting. T. Schmidt moved that the minutes be approved and L. Ness seconded the motion. D. Clinkenbeard called for a voice vote to approve the minutes. The motion passed with no audible dissent.

Budget Update
B. Joyce informed the board members that for the current fiscal year (7/11 – 6/12) the total pharmacy expenditure, net of rebate, was 17.5 million dollars. The actual payment to pharmacies (pre-rebate dollars) during that time was 37.1 million dollars. The unit rebate offset amount that is paid to the federal government was 1.5 million dollars. The class with the highest drug spend is ADHD. In August 2012, the spend for ADHD was approximately $480,000.

Kalydeco Second Review
A motion and second were made at the June meeting to place Kalydeco on prior authorization. The topic was brought up for a second review. There was no public comment. After discussion, D. Clinkenbeard called for a voice vote to approve the motion. The motion passed with no audible dissent.

Kuvan Second Review
A motion and second were made at the June meeting to place Kuvan on prior authorization. The topic was brought up for a second review. There was no public comment. D. Clinkenbeard called for a voice vote to approve the motion. The motion passed with no audible dissent.

Elaprase Second Review
A motion and second were made at the June meeting to place Elaprase on prior authorization. The topic was brought up for a second review. There was no public comment. Chair, G. Pfister called for a voice vote to approve the motion. The motion passed with no audible dissent.

Yearly PA Review
The Board reviews products annually that have previously been placed on prior authorization. This allows the Board a chance to update the prior authorization forms and criteria. DAW, Amrix/Fexmid, Xenical, Zanaflex caps, Ketek, Aczone, Topical Ketoconazole, Clorpres, Gilenya, Livalo, Oravig, Xyrem, Zyclara, Nuedexta, Nexiclon, and Narcotic/APAP combo products were reviewed. No changes were made to the forms and criteria.

Actinic Keratosis Review
B. Joyce reviewed actinic keratosis with the Board. There was no public comment. After discussion, T. Twogood made a motion to place products used to treat actinic keratosis on prior authorization. J. Hostetter seconded the motion. This topic will be brought up at the next meeting for finalization.

Moxeza Review
B. Joyce reviewed Moxeza information with the Board. Rachelle Dorr, representing Alcon, spoke against prior authorization of Moxeza. After discussion, N. Byers made a motion to place Moxeza on prior authorization. L. Ness seconded the motion. This topic will be brought up at the next meeting for finalization.

Lidoderm Review
B. Joyce reviewed Lidoderm information with the Board. There was no public comment. This topic was tabled.

Suboxone Review
B. Joyce reviewed Suboxone information with the Board. Jim Sharp, representing Reckitt Benckiser, spoke regarding Suboxone. This topic was tabled.

Patients Taking Multiple Long-Acting Narcotics and Oxycontin TID Review
B. Joyce reviewed patients taking multiple long-acting narcotics and Oxycontin three times a day with the Board. There was no public comment. After discussion, it was suggested that this topic 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. J. Hostetter moved to approve the new criteria and N. Byers seconded the motion. D. Clinkenbeard called for a voice vote. The motion passed with no audible dissent.

The next DUR board meeting will be held Dec 3rd, 2012 in Bismarck. D. Clinkenbeard made a motion to adjourn the meeting. N. Byers seconded. The motion passed with no audible dissent. D. Clinkenbeard adjourned the meeting at 2:47 pm.

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: □ ZYCLARA □ SOLARAZE □ PICATO	**Diagnosis for this Request:**		
Physician Signature		Date	

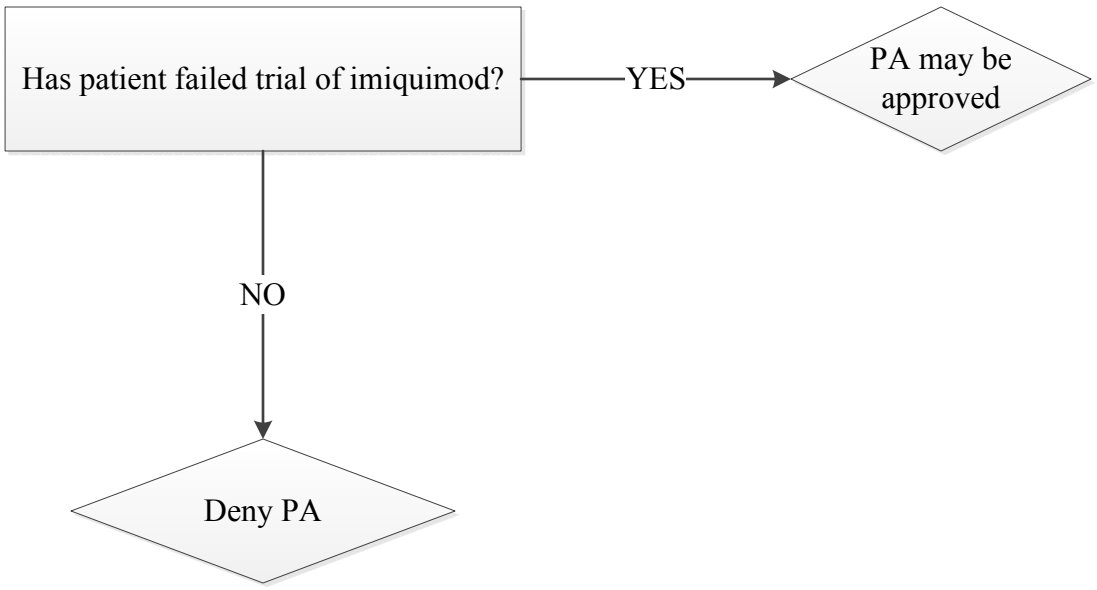
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Actinic Keratosis Authorization Algorithm



MOXEZA 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 Moxeza must have a documented failure of a first line 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 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: □ MOXEZA	**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	

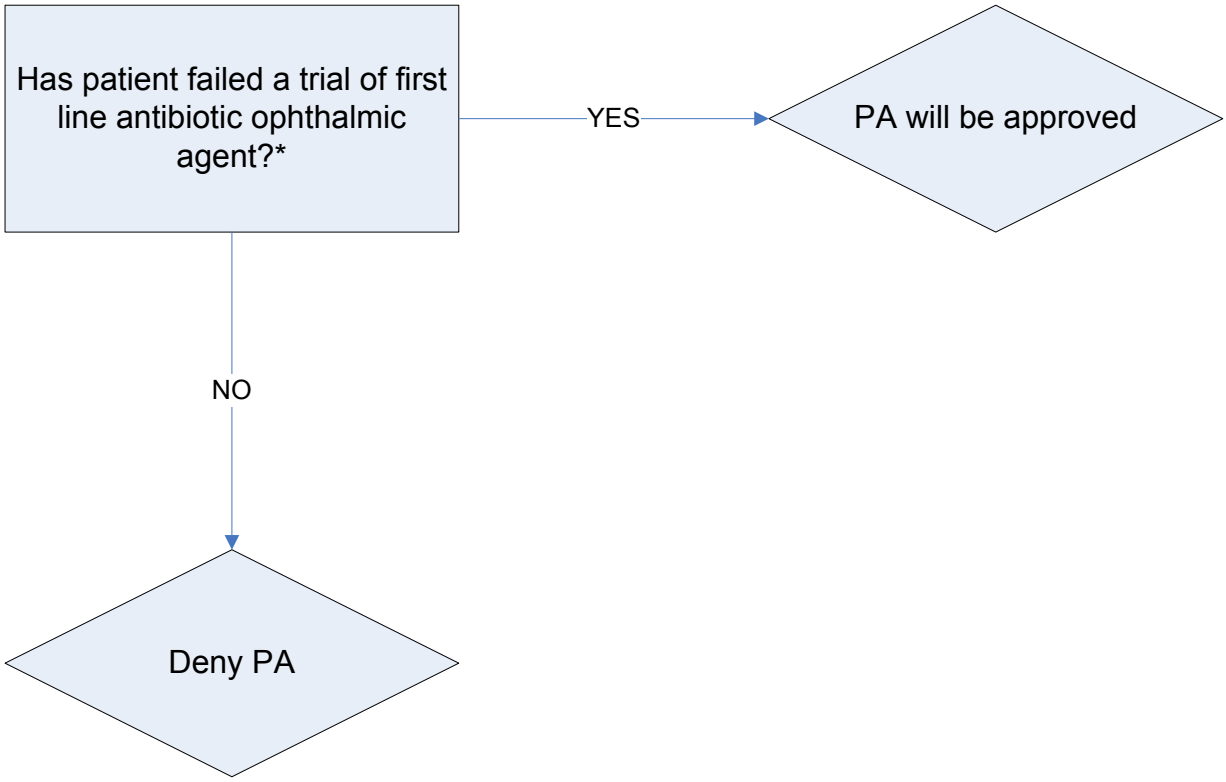
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Moxeza Authorization Algorithm



*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).

North Dakota Medicaid
DUR Board
Duplicate Narcotic Therapy (H3A)

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
15496	1	BUTRANS , FENTANYL , HYDROCODONE-ACETAMINOPHEN , KADIAN , MORPHINE SULFATE , MORPHINE SULFATE ER
15585		BUTRANS , FENTANYL , HYDROCODONE-ACETAMINOPHEN , KADIAN , MORPHINE SULFATE , MORPHINE SULFATE ER
15650		BUTRANS , FENTANYL , HYDROCODONE-ACETAMINOPHEN , KADIAN , MORPHINE SULFATE , MORPHINE SULFATE ER
16297		BUTRANS , FENTANYL , HYDROCODONE-ACETAMINOPHEN , KADIAN , MORPHINE SULFATE , MORPHINE SULFATE ER
16304		BUTRANS , FENTANYL , HYDROCODONE-ACETAMINOPHEN , KADIAN , MORPHINE SULFATE , MORPHINE SULFATE ER
15357	2	ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
18843		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
41412		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
84066		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
13032	3	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
16214		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
10656	4	MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
13306		MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
13688		MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
14590		MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
1679891907		MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
16833		MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
15585	5	ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
1710052626		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
17848		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
41105		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
10757	6	FENTANYL , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL , TRAMADOL HCL
13306		FENTANYL , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL , TRAMADOL HCL
15441		FENTANYL , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL , TRAMADOL HCL
16061		FENTANYL , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL , TRAMADOL HCL
10980	7	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
12215		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
14526		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
18853		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
19584		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
11834	8	ENDOCET , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCONTIN
13959		ENDOCET , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCONTIN
10090	9	FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
11179		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
12823		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
14991		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
15326		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
16112		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
16194		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
19846		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
10852	10	ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
11828		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
12034		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
19869		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , OXYCONTIN

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
17186	11	ENDOCET , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
18063		ENDOCET , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
19827		ENDOCET , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
11085	12	HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
16432		HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
41318		HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
14327	13	DILAUDID , ENDOCET , FENTANYL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
15270		DILAUDID , ENDOCET , FENTANYL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
16437		DILAUDID , ENDOCET , FENTANYL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
1740254739		DILAUDID , ENDOCET , FENTANYL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
84049		DILAUDID , ENDOCET , FENTANYL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
10431	14	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
19887		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
19983		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
84028		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
18865	15	BUTORPHANOL TARTRATE , FENTANYL , HYDROMORPHONE HCL , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
10861	16	HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
12034		HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
13149		HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
13939		HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
1740254739		HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
19869		HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
10756	17	FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
11094		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
1134433857		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL ,

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
		OXYCODONE-ACETAMINOPHEN
13123		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
1326278912		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
14269		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
15333		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
1699087916		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
18084		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
12928	18	FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE HCL
16326	19	HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , TRAMADOL HCL
16475		HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , TRAMADOL HCL
18468		HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , TRAMADOL HCL
10513	20	HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
13415	21	ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , ROXICET
13855		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , ROXICET
15032		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , ROXICET
18911		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , ROXICET
19900		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , ROXICET
12939	21	ENDOCET , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCONTIN
18865		ENDOCET , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCONTIN
15343	22	FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE ER , TRAMADOL HCL
11611	23	HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCONTIN , TRAMADOL HCL
14804		HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCONTIN , TRAMADOL HCL
16162		HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCONTIN , TRAMADOL HCL
1740254739		HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCONTIN , TRAMADOL HCL
1326278912	24	FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE ER , OXYCODONE HCL
1669624813		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE ER , OXYCODONE HCL
1710117312		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE ER , OXYCODONE HCL
1942514666		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE ER , OXYCODONE HCL

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
10321	25	FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
10838		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
11329		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
12941		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
18084		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
1891888582		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
84086		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
10838	26	ENDOCET , MORPHINE SULFATE , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
12071		ENDOCET , MORPHINE SULFATE , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
13615		ENDOCET , MORPHINE SULFATE , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
18911		ENDOCET , MORPHINE SULFATE , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
19842		ENDOCET , MORPHINE SULFATE , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
1740254739	27	MORPHINE SULFATE , MORPHINE SULFATE ER , OPANA ER
19869		MORPHINE SULFATE , MORPHINE SULFATE ER , OPANA ER
12622	28	ENDOCET , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
19552		ENDOCET , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
19591		ENDOCET , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
19593		ENDOCET , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
11179	29	HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER
16112		HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER
19700		HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER
13929	30	OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
12928	31	FENTANYL , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
16162	32	MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
15585	33	MORPHINE SULFATE ER , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
17848		MORPHINE SULFATE ER , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
10195	34	FENTANYL , HYDROCODONE-ACETAMINOPHEN , TRAMADOL HCL
13936		FENTANYL , HYDROCODONE-ACETAMINOPHEN , TRAMADOL HCL
14720	35	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
15441		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
16061		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
		ACETAMINOPHEN
16833		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
19813		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
16458	36	OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL , ULTRAM ER
1083910426	37	KADIAN , MORPHINE SULFATE ER , OXYCODONE HCL
1740254739		KADIAN , MORPHINE SULFATE ER , OXYCODONE HCL
19869		KADIAN , MORPHINE SULFATE ER , OXYCODONE HCL
15457	38	MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
19732		MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
84021		MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
12034	39	MORPHINE SULFATE ER , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
1740254739		MORPHINE SULFATE ER , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
19869		MORPHINE SULFATE ER , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
11894	40	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCONTIN
12079		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCONTIN
16431		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCONTIN
11179	41	HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , MORPHINE SULFATE ER
19700		HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , MORPHINE SULFATE ER
15585	42	FENTANYL , OXYCODONE HCL , TRAMADOL HCL
17848		FENTANYL , OXYCODONE HCL , TRAMADOL HCL
16458	43	HYDROMORPHONE HCL , MORPHINE SULFATE , MORPHINE SULFATE ER
10611	44	MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
10854		MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
12034		MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
1740254739		MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
18780		MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
19869		MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
1740254739	45	FENTANYL , MORPHINE SULFATE ER , OXYCODONE HCL
19869		FENTANYL , MORPHINE SULFATE ER , OXYCODONE HCL
13302	46	FENTANYL , MORPHINE SULFATE ER , OXYCODONE HCL
13537		FENTANYL , MORPHINE SULFATE ER , OXYCODONE HCL
15661		FENTANYL , MORPHINE SULFATE ER , OXYCODONE HCL
11179	47	FENTANYL , HYDROMORPHONE HCL , OXYCODONE HCL
1306995865		FENTANYL , HYDROMORPHONE HCL , OXYCODONE HCL
11277	48	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
14165		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL
14852		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL
14310	49	FENTANYL , HYDROMORPHONE HCL , MORPHINE SULFATE ER
1740254739		FENTANYL , HYDROMORPHONE HCL , MORPHINE SULFATE ER
17684		FENTANYL , HYDROMORPHONE HCL , MORPHINE SULFATE ER
18780		FENTANYL , HYDROMORPHONE HCL , MORPHINE SULFATE ER
19971		FENTANYL , HYDROMORPHONE HCL , MORPHINE SULFATE ER

North Dakota Medicaid
DUR Board
Oxycontin TID

Oxycontin tablets are a controlled-release oral formulation of oxycodone hydrochloride indicated for the management of moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time. Oxycontin is not intended for use on an as needed basis. The controlled-release nature of the formulation allows Oxycontin to be effectively administered every 12 hours.

This report includes all strengths of Oxycontin in which patients were given 69 tablets or more per month, indicating three times a day dosing (TID). From 05/31/11 through 05/30/12 there were 190 scripts of Oxycontin filled with TID dosing. There were 18 recipients **(14% of total)** and 23 prescribers **(16% of total)**. Oxycontin prescribed with TID dosing makes up approximately **47%** of the Oxycontin spend.

Oxycontin TID dosing 05/31/11 – 05/30/12			
Drug Name	**Number of Prescriptions**	**Total Reimb Amount**	**Unique Number of Recipients**
Oxycontin (all)	791	$286,997.57	125
Oxycontin TID	190	$134,734.68	18

Summary by Age of the 18 recipients taking Oxycontin TID:

31-40	2
41-50	5
51-60	10
60 and above	1

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
1	6/7/2011	OXYCONTIN 20 MG TABLET	90	30
	6/7/2011	OXYCONTIN 40 MG TABLET	90	30
	7/2/2011	OXYCONTIN 20 MG TABLET	90	30
	7/2/2011	OXYCONTIN 40 MG TABLET	90	30
	7/29/2011	OXYCONTIN 20 MG TABLET	90	30
	7/29/2011	OXYCONTIN 40 MG TABLET	90	30
	8/24/2011	OXYCONTIN 20 MG TABLET	90	30
	8/24/2011	OXYCONTIN 40 MG TABLET	90	30
	9/21/2011	OXYCONTIN 20 MG TABLET	90	30
	9/21/2011	OXYCONTIN 40 MG TABLET	90	30
	10/18/2011	OXYCONTIN 20 MG TABLET	90	30
	10/18/2011	OXYCONTIN 40 MG TABLET	90	30
	11/14/2011	OXYCONTIN 20 MG TABLET	84	28
	12/12/2011	OXYCONTIN 20 MG TABLET	84	28

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
1 (cont'd)	12/13/2011	OXYCONTIN 40 MG TABLET	84	28
	1/13/2012	OXYCONTIN 20 MG TABLET	84	28
	1/20/2012	OXYCONTIN 40 MG TABLET	84	28
	2/8/2012	OXYCONTIN 20 MG TABLET	84	28
	2/14/2012	OXYCONTIN 40 MG TABLET	84	28
	3/13/2012	OXYCONTIN 20 MG TABLET	84	28
	3/13/2012	OXYCONTIN 40 MG TABLET	84	28
	4/11/2012	OXYCONTIN 20 MG TABLET	84	28
	4/11/2012	OXYCONTIN 40 MG TABLET	84	28
	5/8/2012	OXYCONTIN 20 MG TABLET	84	28
	5/8/2012	OXYCONTIN 40 MG TABLET	84	28
2	6/16/2011	OXYCONTIN 20 MG TABLET	84	28
	6/20/2011	OXYCONTIN 40 MG TABLET	84	28
	7/15/2011	OXYCONTIN 20 MG TABLET	84	28
	7/19/2011	OXYCONTIN 40 MG TABLET	84	28
	8/15/2011	OXYCONTIN 20 MG TABLET	84	28
	8/19/2011	OXYCONTIN 40 MG TABLET	84	28
	9/15/2011	OXYCONTIN 20 MG TABLET	84	28
	9/19/2011	OXYCONTIN 40 MG TABLET	84	28
	10/15/2011	OXYCONTIN 20 MG TABLET	84	28
	10/18/2011	OXYCONTIN 40 MG TABLET	84	28
	11/15/2011	OXYCONTIN 20 MG TABLET	90	22
	11/18/2011	OXYCONTIN 40 MG TABLET	90	30
	12/16/2011	OXYCONTIN 40 MG TABLET	90	30
	12/19/2011	OXYCONTIN 20 MG TABLET	90	30
	1/16/2012	OXYCONTIN 40 MG TABLET	90	30
	1/18/2012	OXYCONTIN 20 MG TABLET	90	30
	2/15/2012	OXYCONTIN 40 MG TABLET	90	30
	2/16/2012	OXYCONTIN 20 MG TABLET	90	30
	3/15/2012	OXYCONTIN 40 MG TABLET	90	30
	3/16/2012	OXYCONTIN 20 MG TABLET	90	30
	4/13/2012	OXYCONTIN 40 MG TABLET	90	30
	4/14/2012	OXYCONTIN 20 MG TABLET	90	30
	5/12/2012	OXYCONTIN 40 MG TABLET	120	30
	5/14/2012	OXYCONTIN 20 MG TABLET	120	30
3	11/18/2011	OXYCONTIN 20 MG TABLET	90	30
	11/18/2011	OXYCONTIN 80 MG TABLET	90	30
	12/16/2011	OXYCONTIN 20 MG TABLET	90	30
	12/16/2011	OXYCONTIN 80 MG TABLET	120	30
	1/13/2012	OXYCONTIN 20 MG TABLET	120	30
	1/13/2012	OXYCONTIN 80 MG TABLET	120	30
	2/10/2012	OXYCONTIN 20 MG TABLET	120	30
	2/10/2012	OXYCONTIN 80 MG TABLET	120	30

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
3 (cont'd)	3/8/2012	OXYCONTIN 20 MG TABLET	120	30
	3/8/2012	OXYCONTIN 80 MG TABLET	120	30
	4/6/2012	OXYCONTIN 20 MG TABLET	120	30
	4/6/2012	OXYCONTIN 80 MG TABLET	120	30
	5/6/2012	OXYCONTIN 20 MG TABLET	120	30
	5/6/2012	OXYCONTIN 80 MG TABLET	120	30
4	11/8/2011	OXYCONTIN 20 MG TABLET	120	30
	12/7/2011	OXYCONTIN 40 MG TABLET	90	30
5	6/9/2011	OXYCONTIN 20 MG TABLET	90	30
	6/9/2011	OXYCONTIN 40 MG TABLET	90	30
	7/8/2011	OXYCONTIN 20 MG TABLET	90	30
	7/8/2011	OXYCONTIN 40 MG TABLET	90	30
	8/12/2011	OXYCONTIN 20 MG TABLET	90	30
	8/12/2011	OXYCONTIN 40 MG TABLET	90	30
	9/21/2011	OXYCONTIN 20 MG TABLET	90	30
	9/21/2011	OXYCONTIN 40 MG TABLET	90	30
	10/27/2011	OXYCONTIN 20 MG TABLET	90	30
	10/27/2011	OXYCONTIN 40 MG TABLET	90	30
	12/1/2011	OXYCONTIN 20 MG TABLET	90	30
	12/1/2011	OXYCONTIN 40 MG TABLET	90	30
	1/6/2012	OXYCONTIN 20 MG TABLET	90	30
	1/6/2012	OXYCONTIN 40 MG TABLET	90	30
	2/10/2012	OXYCONTIN 20 MG TABLET	90	30
	2/10/2012	OXYCONTIN 40 MG TABLET	90	30
	3/7/2012	OXYCONTIN 20 MG TABLET	90	30
	3/7/2012	OXYCONTIN 40 MG TABLET	90	30
	4/20/2012	OXYCONTIN 20 MG TABLET	90	30
	4/20/2012	OXYCONTIN 40 MG TABLET	90	30
	5/24/2012	OXYCONTIN 20 MG TABLET	90	30
	5/24/2012	OXYCONTIN 40 MG TABLET	90	30
6	4/24/2012	OXYCONTIN 80 MG TABLET	90	30
	5/24/2012	OXYCONTIN 80 MG TABLET	90	30
7	6/9/2011	OXYCONTIN 80 MG TABLET	90	30
	7/12/2011	OXYCONTIN 80 MG TABLET	90	30
	8/10/2011	OXYCONTIN 80 MG TABLET	90	30
	9/10/2011	OXYCONTIN 80 MG TABLET	90	30
	10/8/2011	OXYCONTIN 80 MG TABLET	90	30
	11/11/2011	OXYCONTIN 80 MG TABLET	90	30
	12/10/2011	OXYCONTIN 80 MG TABLET	90	30
	1/9/2012	OXYCONTIN 80 MG TABLET	90	30
	2/9/2012	OXYCONTIN 80 MG TABLET	90	30

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
7 (cont'd)	3/7/2012	OXYCONTIN 80 MG TABLET	90	30
	4/18/2012	OXYCONTIN 80 MG TABLET	90	30
	5/17/2012	OXYCONTIN 80 MG TABLET	90	30
8	6/17/2011	OXYCONTIN 40 MG TABLET	90	30
	7/22/2011	OXYCONTIN 40 MG TABLET	90	30
	8/22/2011	OXYCONTIN 40 MG TABLET	90	30
	9/22/2011	OXYCONTIN 40 MG TABLET	90	30
	10/22/2011	OXYCONTIN 40 MG TABLET	90	30
	11/28/2011	OXYCONTIN 40 MG TABLET	90	30
	12/30/2011	OXYCONTIN 40 MG TABLET	90	30
	2/2/2012	OXYCONTIN 40 MG TABLET	90	30
	3/5/2012	OXYCONTIN 40 MG TABLET	90	30
	4/2/2012	OXYCONTIN 40 MG TABLET	90	30
	5/1/2012	OXYCONTIN 40 MG TABLET	90	30
9	6/13/2011	OXYCONTIN 80 MG TABLET	90	30
	7/14/2011	OXYCONTIN 80 MG TABLET	90	30
	8/11/2011	OXYCONTIN 80 MG TABLET	90	30
	9/15/2011	OXYCONTIN 80 MG TABLET	90	30
	10/21/2011	OXYCONTIN 80 MG TABLET	90	30
	11/21/2011	OXYCONTIN 80 MG TABLET	90	30
	12/23/2011	OXYCONTIN 80 MG TABLET	90	30
	1/20/2012	OXYCONTIN 80 MG TABLET	90	30
	2/18/2012	OXYCONTIN 80 MG TABLET	90	30
	3/19/2012	OXYCONTIN 80 MG TABLET	90	30
	4/17/2012	OXYCONTIN 80 MG TABLET	90	30
	5/24/2012	OXYCONTIN 80 MG TABLET	90	30
10	6/22/2011	OXYCONTIN 20 MG TABLET	90	30
	7/18/2011	OXYCONTIN 20 MG TABLET	90	30
	8/22/2011	OXYCONTIN 20 MG TABLET	90	30
	9/20/2011	OXYCONTIN 20 MG TABLET	90	30
11	6/28/2011	OXYCONTIN 40 MG TABLET	90	30
	7/27/2011	OXYCONTIN 40 MG TABLET	84	28
	8/23/2011	OXYCONTIN 40 MG TABLET	84	28
	9/20/2011	OXYCONTIN 40 MG TABLET	84	28
	10/15/2011	OXYCONTIN 40 MG TABLET	84	28
	11/14/2011	OXYCONTIN 40 MG TABLET	84	28
	12/15/2011	OXYCONTIN 40 MG TABLET	84	28
12	6/10/2011	OXYCONTIN 40 MG TABLET	84	28
	7/6/2011	OXYCONTIN 40 MG TABLET	84	28
	8/3/2011	OXYCONTIN 40 MG TABLET	84	28

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
12 (cont'd)	8/29/2011	OXYCONTIN 40 MG TABLET	84	28
	10/3/2011	OXYCONTIN 40 MG TABLET	84	28
13	5/31/2011	OXYCONTIN 40 MG TABLET	84	28
	6/30/2011	OXYCONTIN 40 MG TABLET	90	30
	8/25/2011	OXYCONTIN 40 MG TABLET	90	30
	9/23/2011	OXYCONTIN 40 MG TABLET	90	30
	10/18/2011	OXYCONTIN 40 MG TABLET	90	30
	11/12/2011	OXYCONTIN 40 MG TABLET	90	30
	12/8/2011	OXYCONTIN 40 MG TABLET	90	30
	1/27/2012	OXYCONTIN 40 MG TABLET	90	30
	2/27/2012	OXYCONTIN 40 MG TABLET	90	30
14	6/24/2011	OXYCONTIN 10 MG TABLET	90	30
	7/25/2011	OXYCONTIN 10 MG TABLET	90	30
	8/24/2011	OXYCONTIN 10 MG TABLET	90	30
	9/23/2011	OXYCONTIN 10 MG TABLET	90	30
	10/21/2011	OXYCONTIN 10 MG TABLET	90	30
	11/18/2011	OXYCONTIN 10 MG TABLET	90	30
	12/16/2011	OXYCONTIN 10 MG TABLET	90	30
	1/13/2012	OXYCONTIN 10 MG TABLET	90	30
	2/10/2012	OXYCONTIN 10 MG TABLET	90	30
	3/12/2012	OXYCONTIN 10 MG TABLET	90	30
	4/9/2012	OXYCONTIN 10 MG TABLET	90	30
15	8/31/2011	OXYCONTIN 80 MG TABLET	90	30
	9/29/2011	OXYCONTIN 80 MG TABLET	90	30
	3/29/2012	OXYCONTIN 80 MG TABLET	90	30
	4/28/2012	OXYCONTIN 80 MG TABLET	90	30
	5/26/2012	OXYCONTIN 80 MG TABLET	90	30
16	6/8/2011	OXYCONTIN 40 MG TABLET	90	30
	7/13/2011	OXYCONTIN 40 MG TABLET	90	30
	8/10/2011	OXYCONTIN 40 MG TABLET	90	30
	9/6/2011	OXYCONTIN 40 MG TABLET	90	30
	10/3/2011	OXYCONTIN 40 MG TABLET	90	30
	10/31/2011	OXYCONTIN 40 MG TABLET	90	30
	11/23/2011	OXYCONTIN 40 MG TABLET	90	30
	1/18/2012	OXYCONTIN 20 MG TABLET	90	30
	2/15/2012	OXYCONTIN 20 MG TABLET	90	30
	3/13/2012	OXYCONTIN 20 MG TABLET	90	30
	4/11/2012	OXYCONTIN 20 MG TABLET	90	30
	5/9/2012	OXYCONTIN 20 MG TABLET	90	30
17	7/11/2011	OXYCONTIN 80 MG TABLET	90	30

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
17 (cont'd)	8/6/2011	OXYCONTIN 80 MG TABLET	90	30
	9/2/2011	OXYCONTIN 80 MG TABLET	84	28
	9/29/2011	OXYCONTIN 80 MG TABLET	84	28
	10/31/2011	OXYCONTIN 80 MG TABLET	90	30
	11/28/2011	OXYCONTIN 80 MG TABLET	90	30
	12/28/2011	OXYCONTIN 80 MG TABLET	90	30
	1/24/2012	OXYCONTIN 80 MG TABLET	90	30
	2/22/2012	OXYCONTIN 80 MG TABLET	90	30
	3/22/2012	OXYCONTIN 80 MG TABLET	90	30
	4/18/2012	OXYCONTIN 80 MG TABLET	90	30
	5/16/2012	OXYCONTIN 80 MG TABLET	93	31
18	5/18/2012	OXYCONTIN 10 MG TABLET	90	30

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

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 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

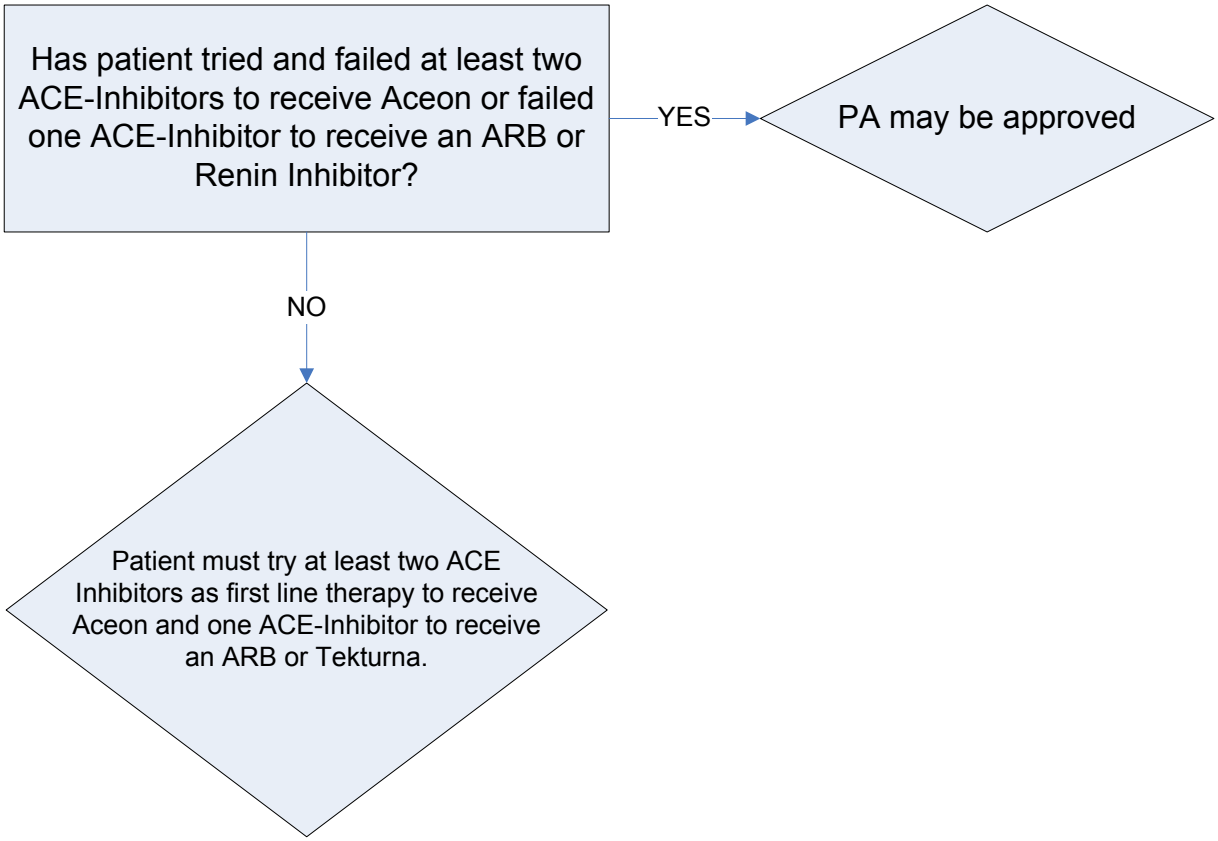
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

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



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

ARB: Micardis, Teveten, Atacand, Avapro, Benicar, Cozaar, Diovan, Edarbi, and hydrochlorothiazide combinations

Renin Inhibitor: Tekturna and hydrochlorothiazide combination

ACTO*plus* met 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 receive Actos and Metformin separately.
Note:

- ***Actos does not require PA***
- ***Metformin does not require PA***
- ***Patients must fail therapy on Actos and Metformin separately 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: □ **ACTO*plus* met**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Failed both drugs separately	Start Date: End Date:	Dose: Frequency:	
Prescriber Signature		Date	

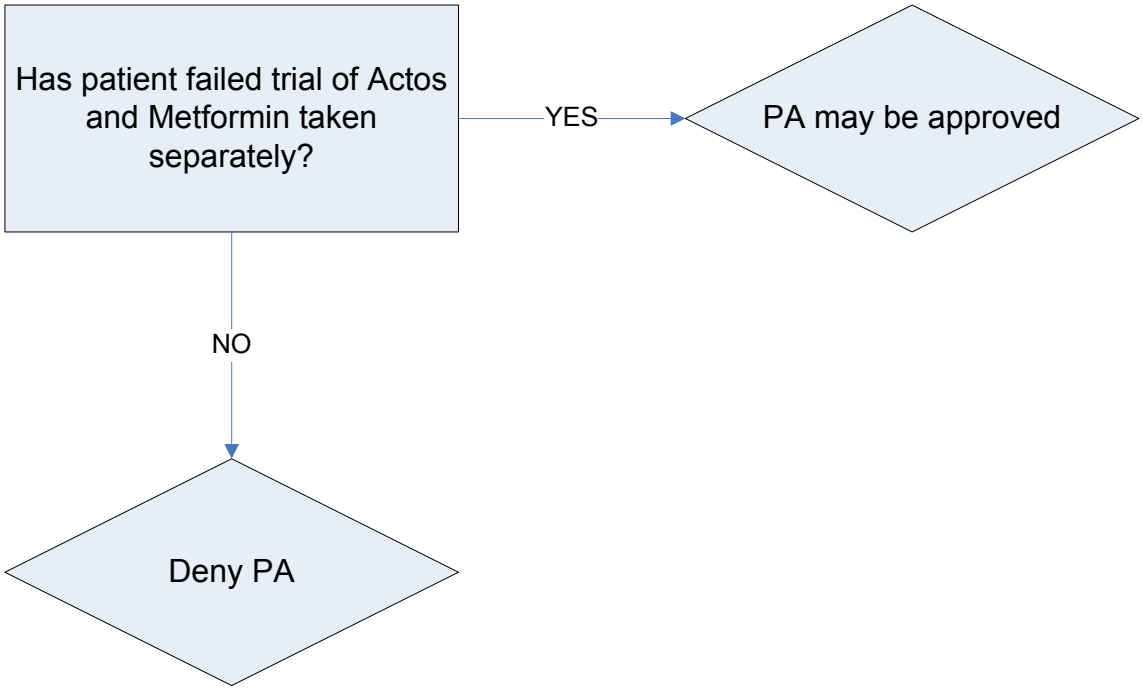
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
ACTO*plus met* Authorization Algorithm



Aczone Gel PA FORM

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 new prescription for Aczone gel must try other topical acne agents as first line therapy.

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: □ ACZONE GEL	**Diagnosis for this request:**		

Qualifications for coverage:

□ Failed acne therapy Name of medication failed: _____	Start Date	End Date	Dose	Frequency

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber Signature	Date

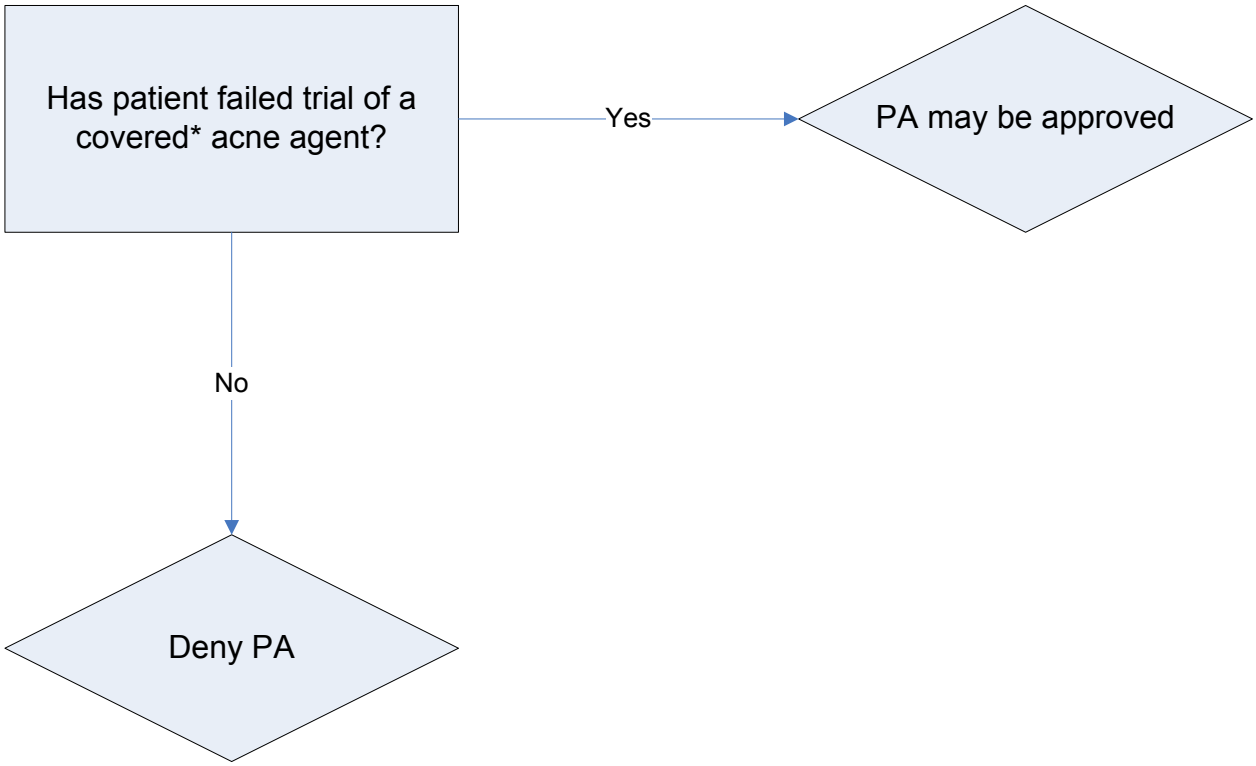
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Aczone Authorization Algorithm



*Tretinoin and benzoyl peroxide products do not require a PA

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: □ 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		

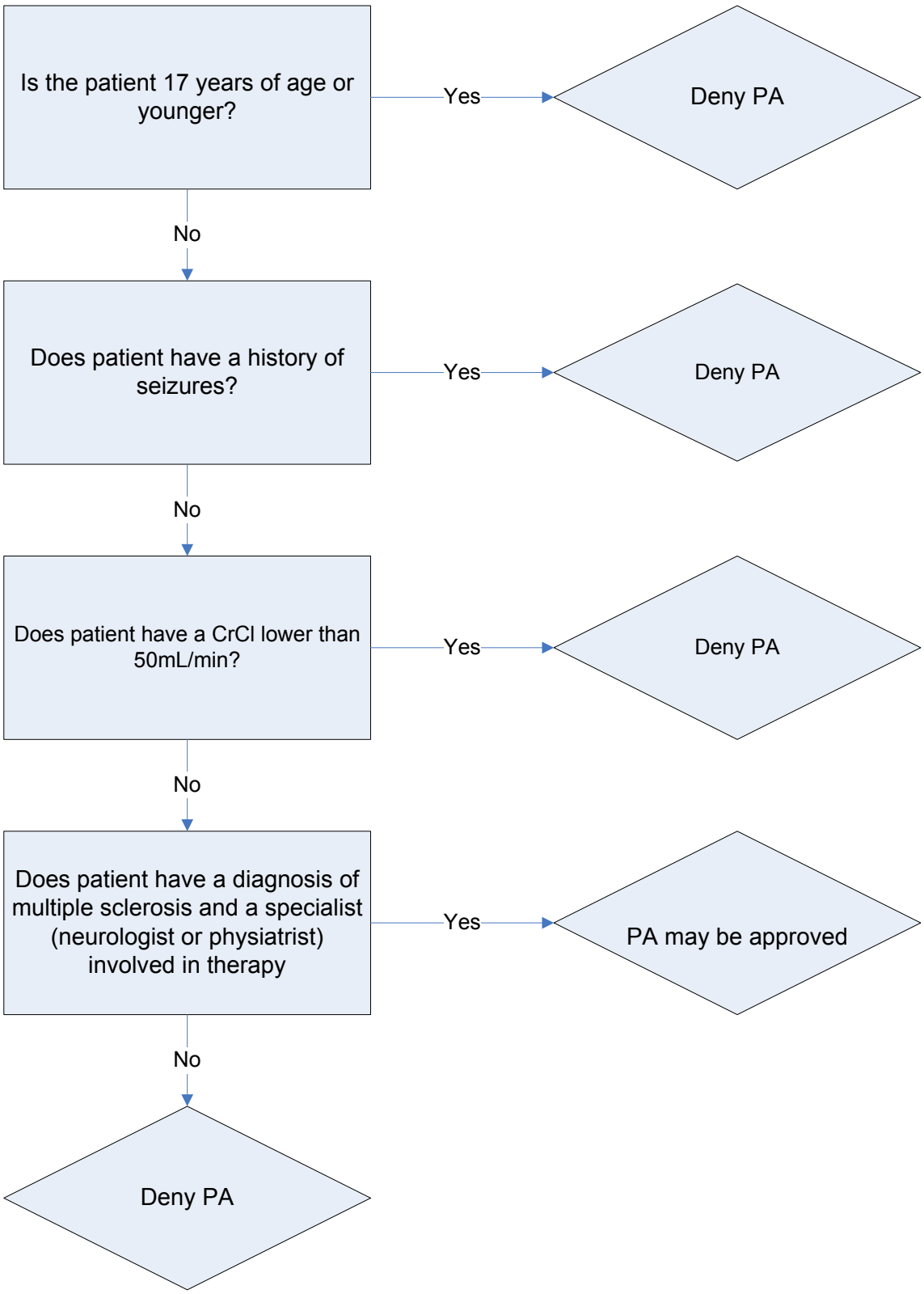
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Ampyra Prior Authorization Algorithm



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:	Dose:
	End Date:	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:

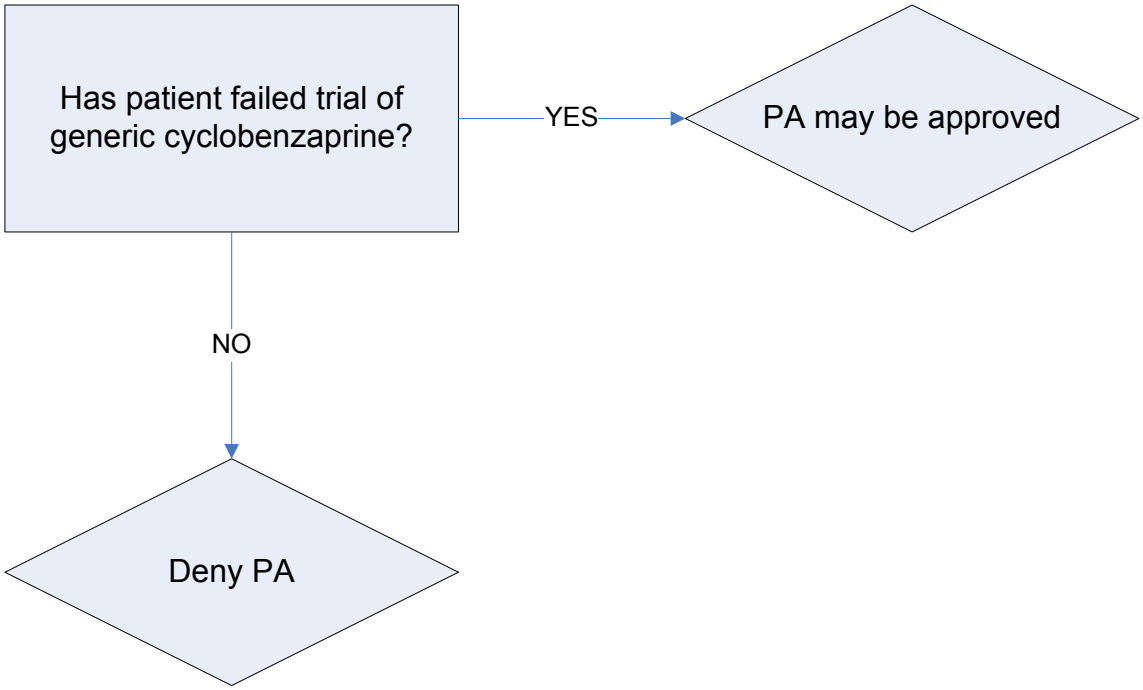
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Amrix Authorization Algorithm



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: □ **ALLEGRA (GENERIC)** □ **CLARINEX** □ **XYZAL**	**Requested Dosage:** (must be completed) **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:

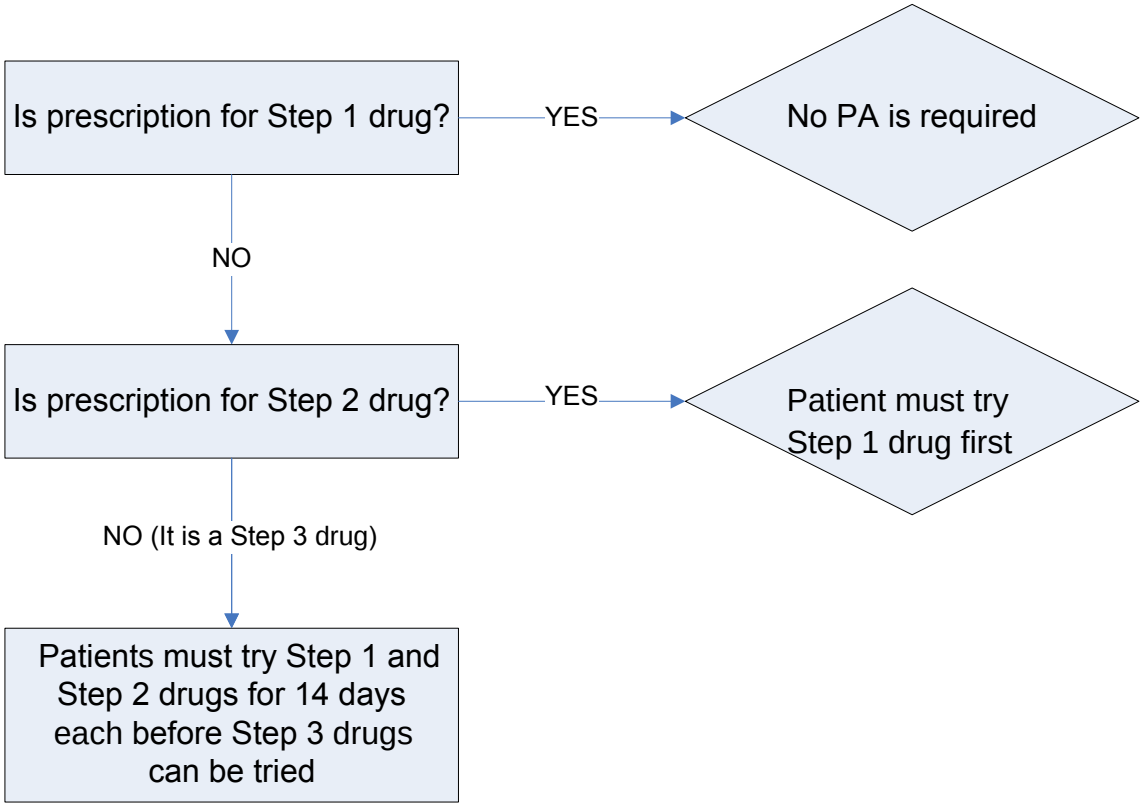
Part II: TO BE COMPLETED BY PHARMACY

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)	

North Dakota Department of Human Services
Antihistamine Authorization Criteria Algorithm



Please Note:

Step 1 drug is defined as Loratadine OTC or Cetirizine
Step 2 drug is defined as Allegra (generic)
Step 3 drug is defined as Clarinex or Xyzal-must try Step 1 and Step 2 drugs before trying Step 3.

Net cost to Medicaid: Loratadine = cetirizine << Allegra (generic) << Clarinex = Xyzal

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: □ **Asacol HD**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED ASACOL THERAPY START DATE: DOSE: END DATE: FREQUENCY:			
Physician Signature		Date	

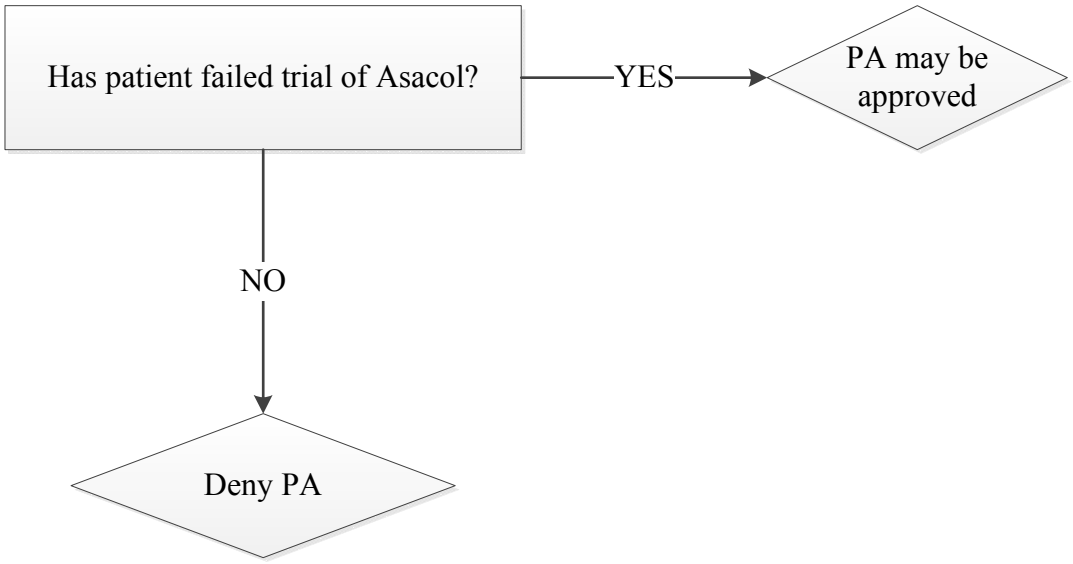
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Asacol HD Authorization Algorithm



For the treatment of moderately active ulcerative colitis: The recommended dose of Asacol HD in adults is two 800 mg tablets to be taken three times daily with or without food, for a total daily dose of 4.8 g for a duration of 6 weeks. $987.84

For the treatment of mildly to moderately active ulcerative colitis: The usual dosage in adults is two 400-mg tablets to be taken three times a day for a total daily dose of 2.4 grams for a duration of 6 weeks. $493.92

For the maintenance of remission of ulcerative colitis: The recommended dosage in adults is 1.6 grams daily, in divided doses.

BLOOD FACTOR PRODUCTS 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 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:	

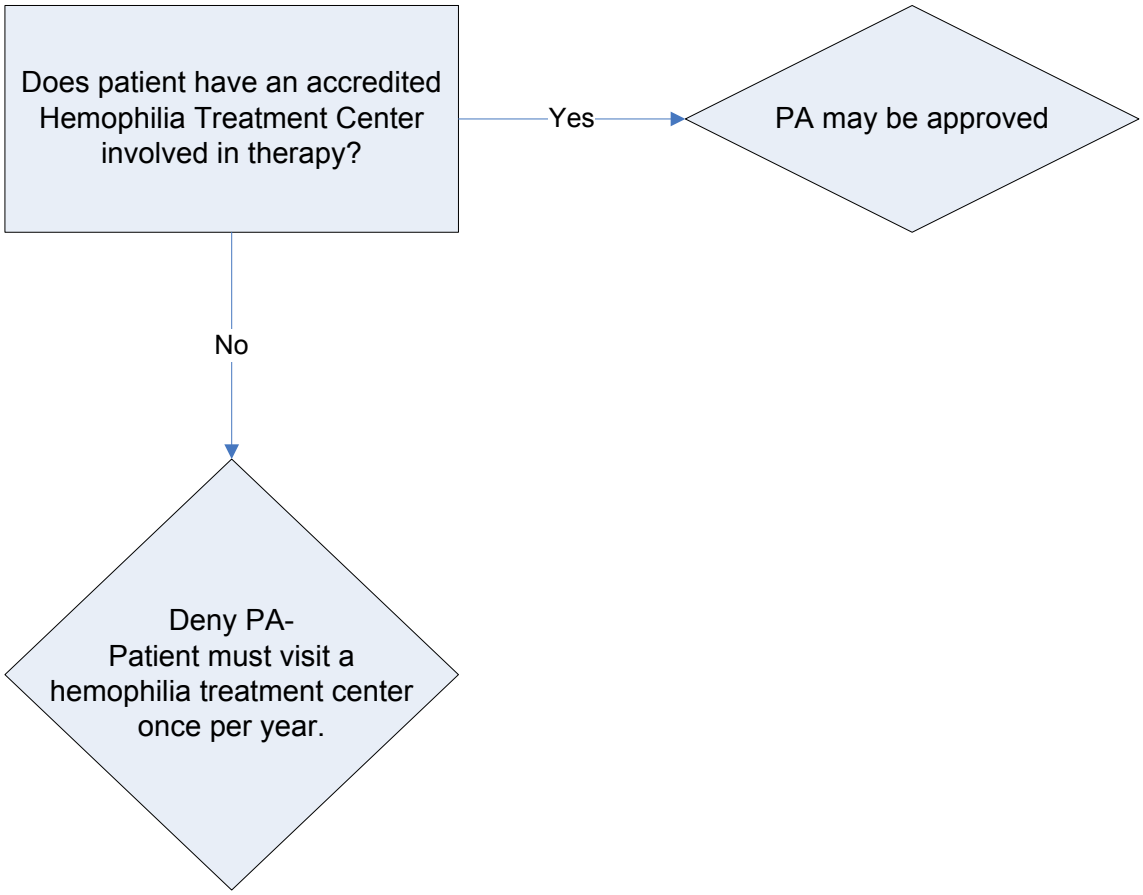
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Blood Factor Products Authorization Algorithm



CARISOPRODOL 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 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: □ 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		

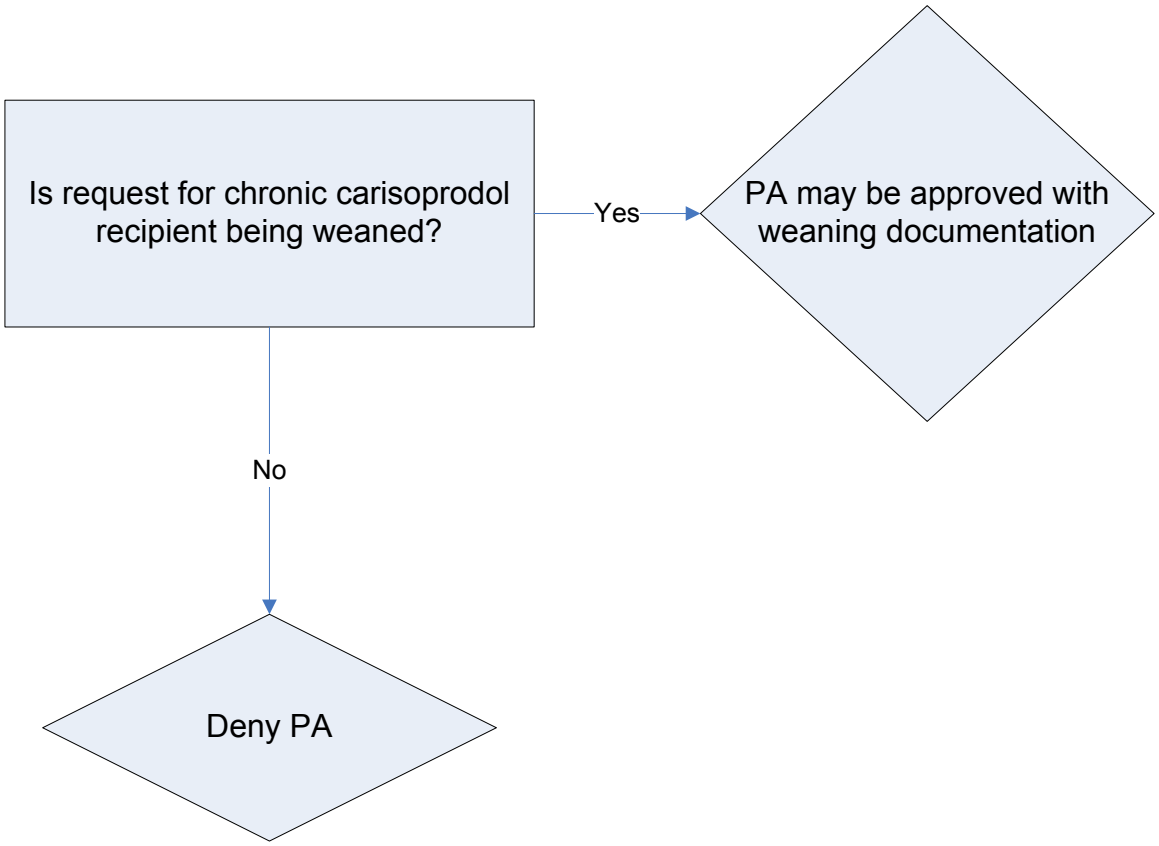
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Carisoprodol Authorization Algorithm



Clorpres 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 receive clonidine and chlorthalidone separately.
Note:

- ***Clonidine does not require PA***
- ***Chlorthalidone 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: □ **Clorpres**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Failed both drugs separately	Start Date: End Date:	Dose: Frequency:	
Physician Signature		Date	

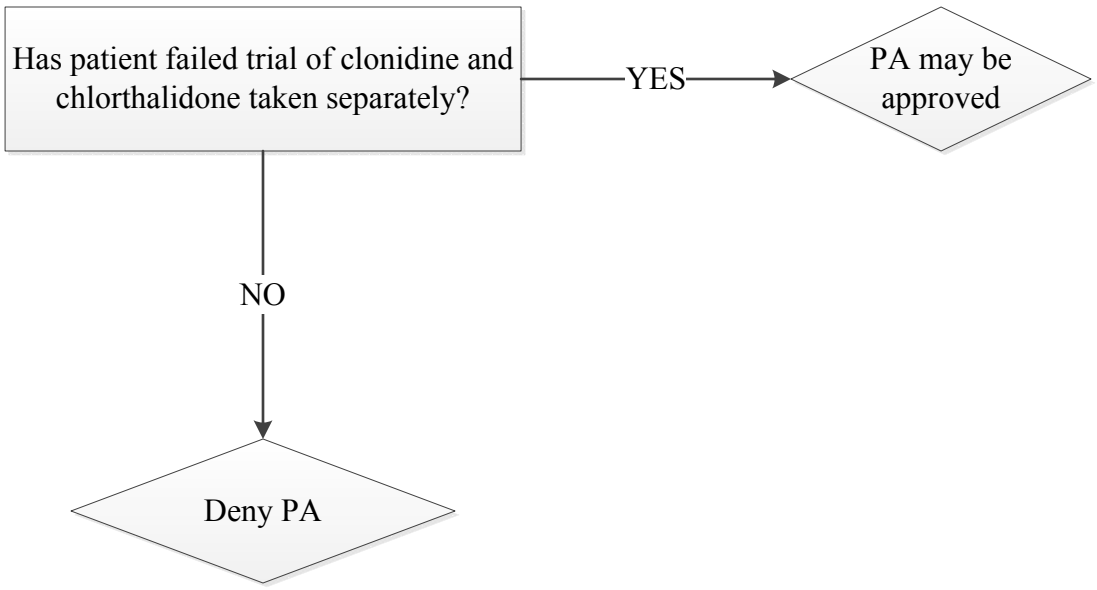
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Clorpres Authorization Algorithm



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: □ **Daliresp**	**Diagnosis for this request:**		
Physician Signature		Date	

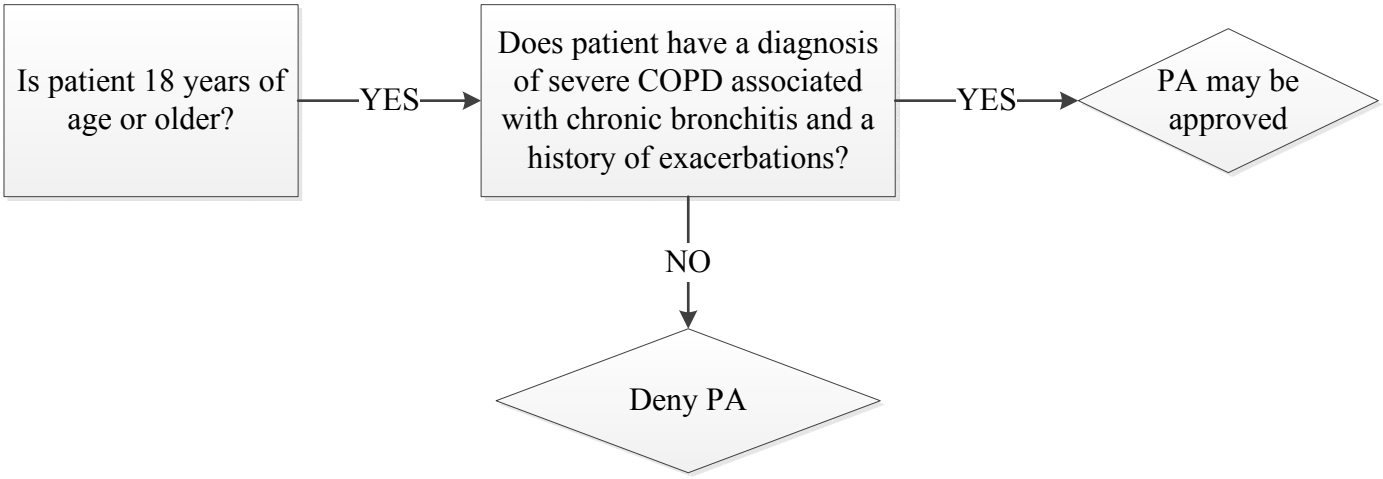
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Daliresp Authorization Algorithm



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: □ DIFICID	**Diagnosis for this Request:**	**Failed therapy:** **Start Date:** **End Date:**
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*		
Prescriber Signature		Date

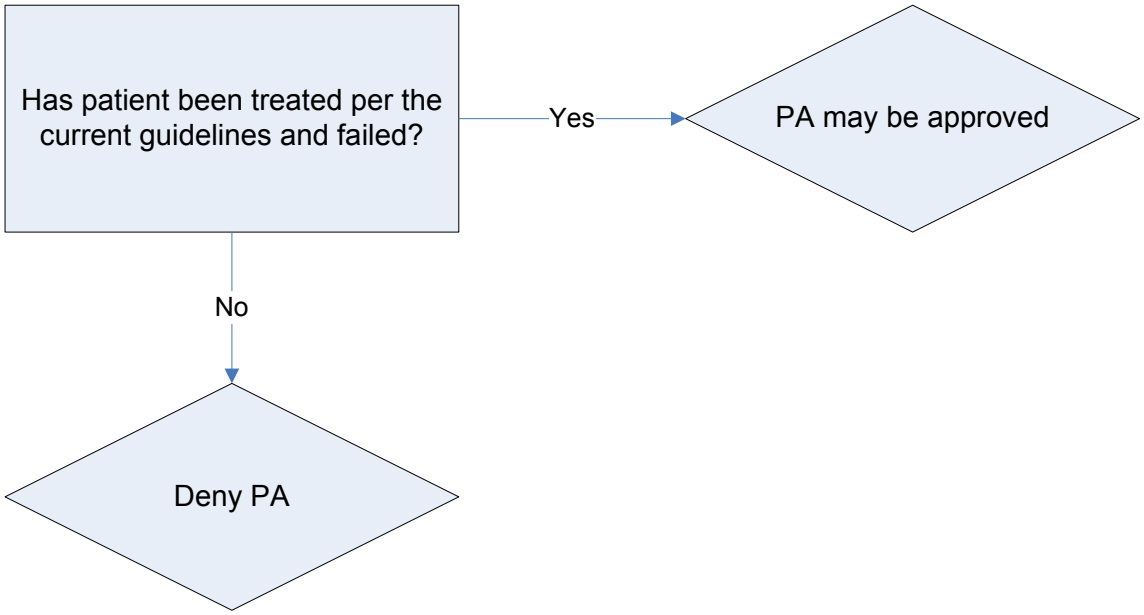
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Dificid Prior Authorization Algorithm



- 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:
  - Initial episode (mild to moderate severity)-metronidazole
  - Initial episode (severe)-vancomycin*
  - Initial episode (severe, complicated)-vancomycin* and metronidazole)
  - First recurrence-same regimen as first episode
  - Second recurrence-oral vancomycin* in tapered regimen

*Compounded oral vancomycin is covered without prior authorization

*Metronidazole is covered without prior authorization

HEALTH INFORMATION DESIGNS

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: ☐ 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 - 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: □ **Gilenya**	**Diagnosis for this request:**		
Qualifications for coverage:			
Current electrocardiogram **Date:**	**Current CBC** **Date:**	**Ophthalmologic Evaluation** **Date:**	**Transaminase/Bilirubin levels** **Date:**
Physician Signature			Date

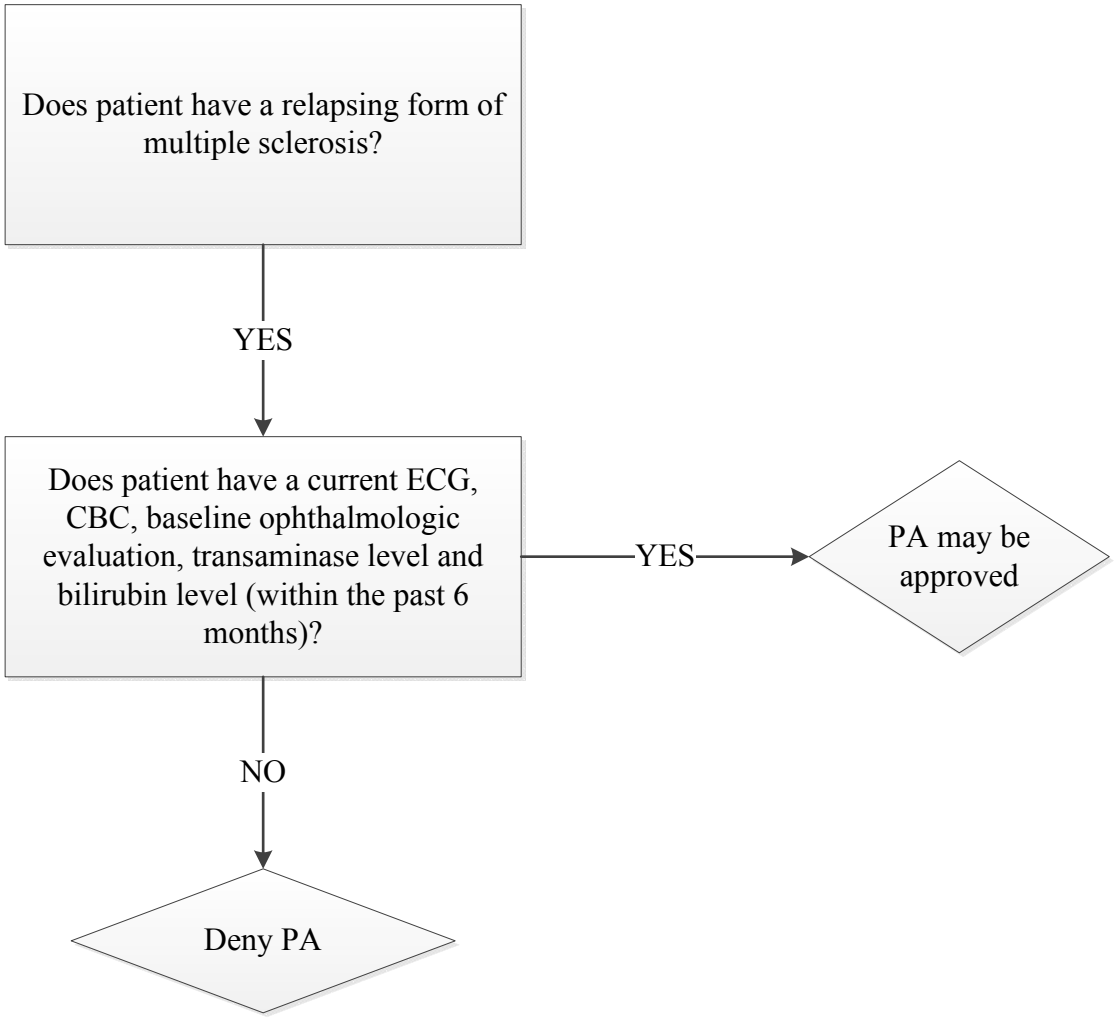
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Gilenya Authorization Algorithm



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: Drug:	Dose: Frequency:
PRESCRIBER SIGNATURE	DATE:	

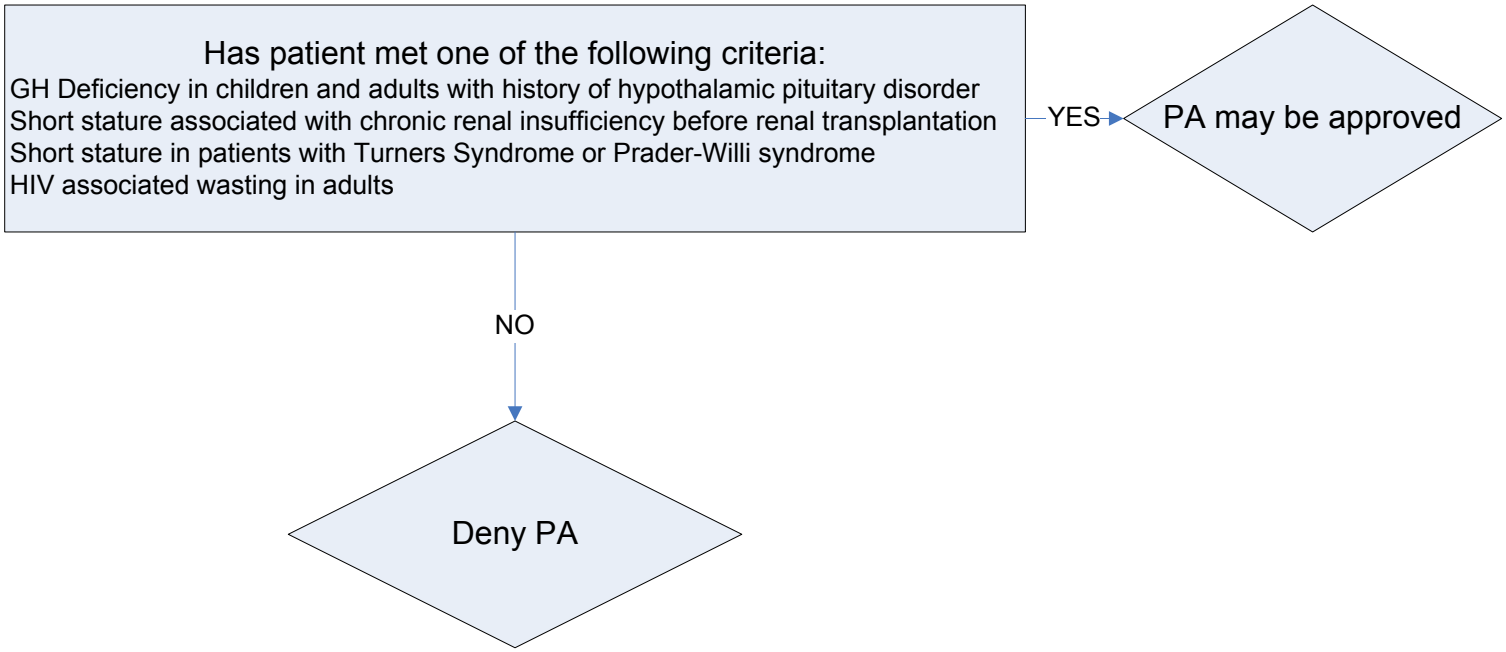
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Growth Hormone Authorization Algorithm



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: □ **Intron** □ **Pegasys** □ **Infergen** □ **PEGIntron** □ **Incivek** □ **Victrelis**	**Diagnosis for this request:** **Ribavirin dose:** **Peg-interferon dose:**	**Genotype:**	
Physician Signature		Date	

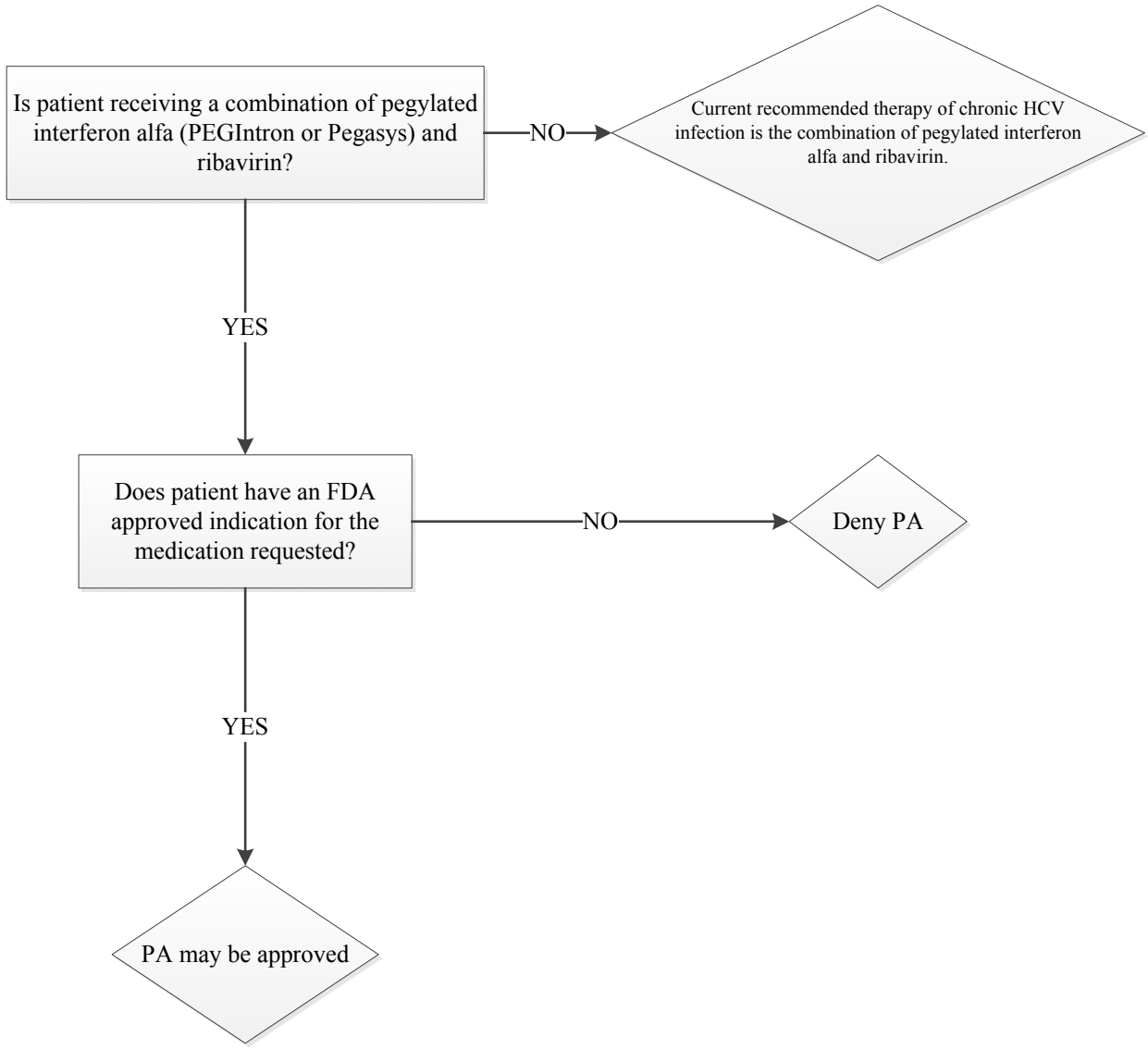
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Hepatitis C Virus (HCV) Medication Authorization Algorithm



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: □ BERINERT □ FIRAZYR □ CINRYZE □ KALBITOR	**Diagnosis for this Request:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber Signature	Date		

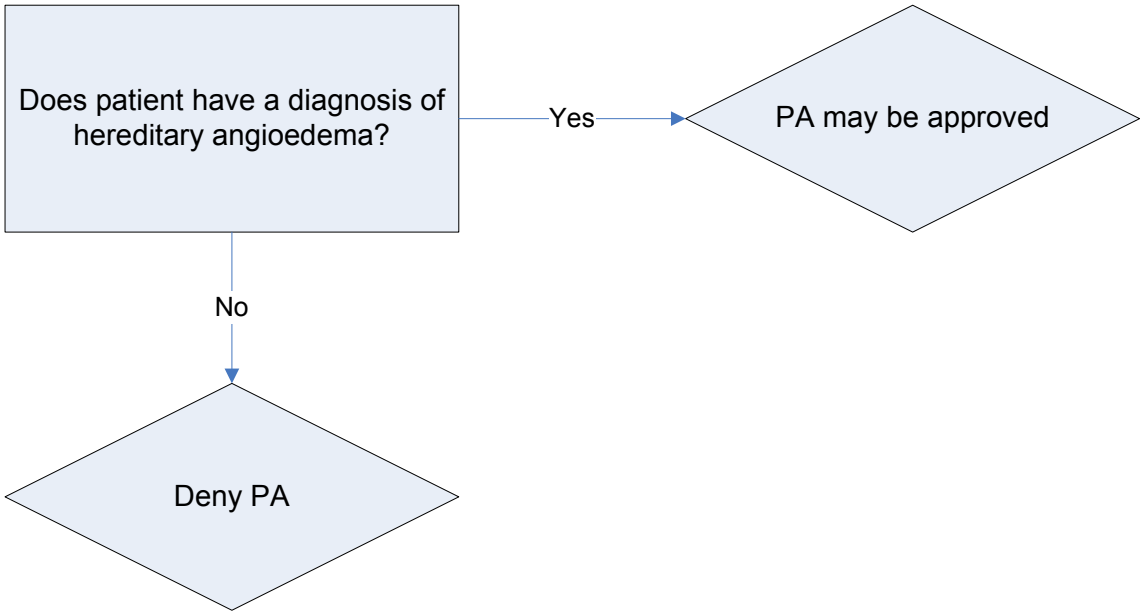
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Hereditary Angioedema Prior Authorization Algorithm



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: □ **Horizant**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED THERAPY START DATE: END DATE:	DOSE: FREQUENCY:		
Physician Signature		Date	

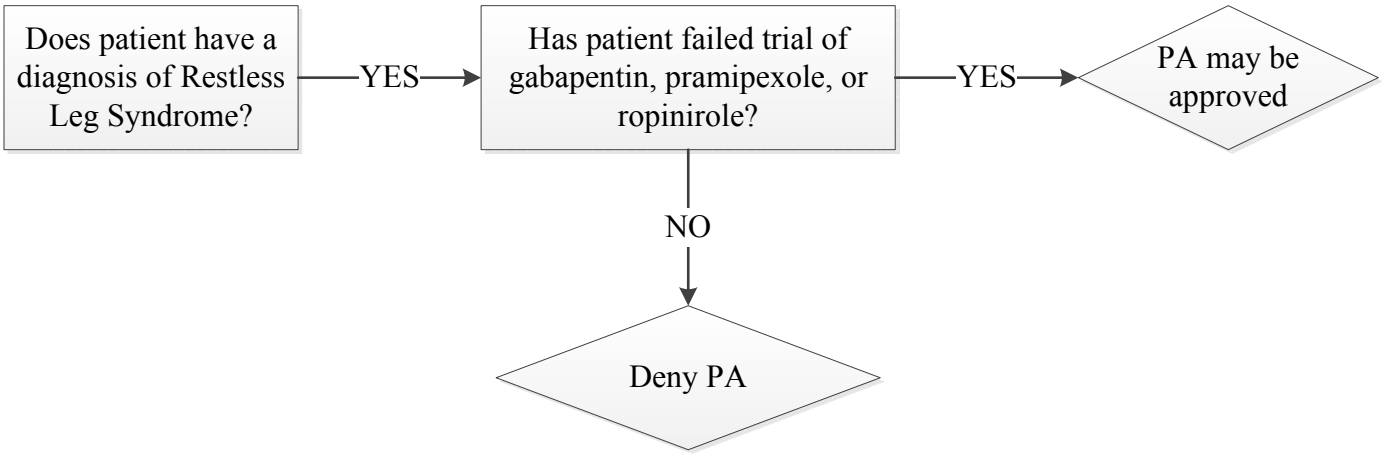
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Horizant Authorization Algorithm



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:		**FDA Approved Indication for this request:**
□ ORENCIA	□ AMEVIVE	
□ ENBREL	□ CIMZIA	
□ KINERET	□ REMICADE	
□ HUMIRA	□ SIMPONI	
□ STELARA	□ ACTEMRA	

□ *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

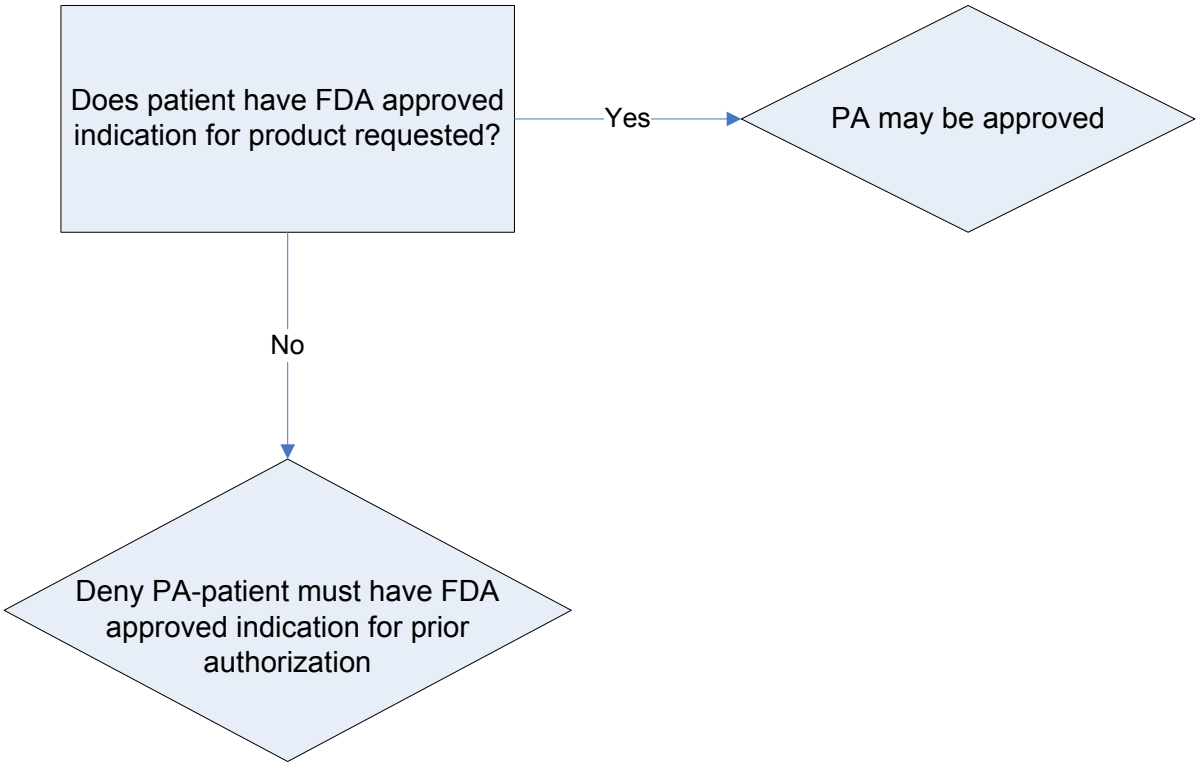
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Targeted Immune Modulators Authorization Algorithm



HEALTH INFORMATION DESIGNS

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: □ **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:

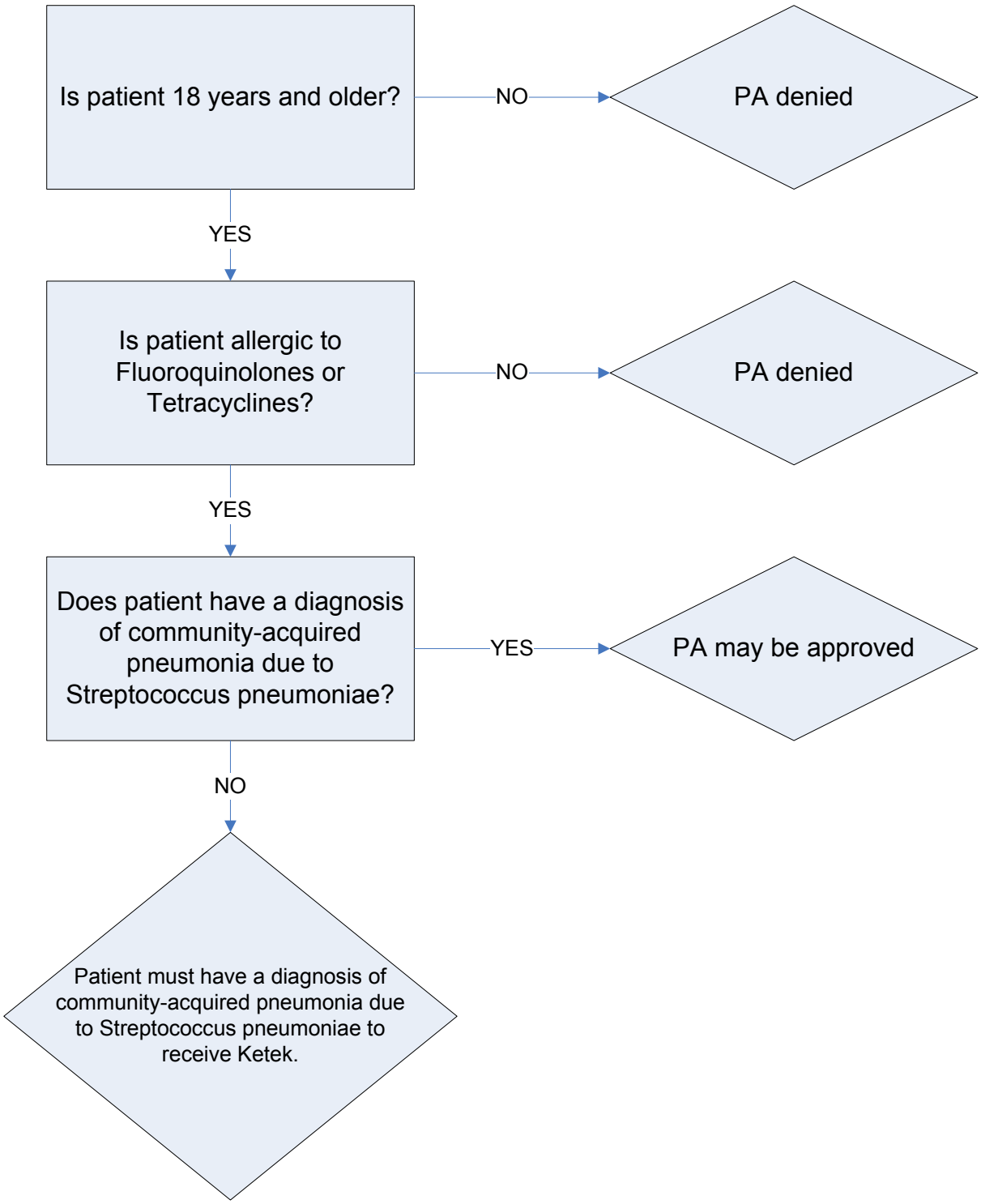
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Ketek Criteria Algorithm



Livalo 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 Livalo must first try a covered statin medication
Note:

- ***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: □ **Livalo**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Medication Failed _____	Start Date: End Date:	Dose: Frequency:	
Physician Signature		Date	

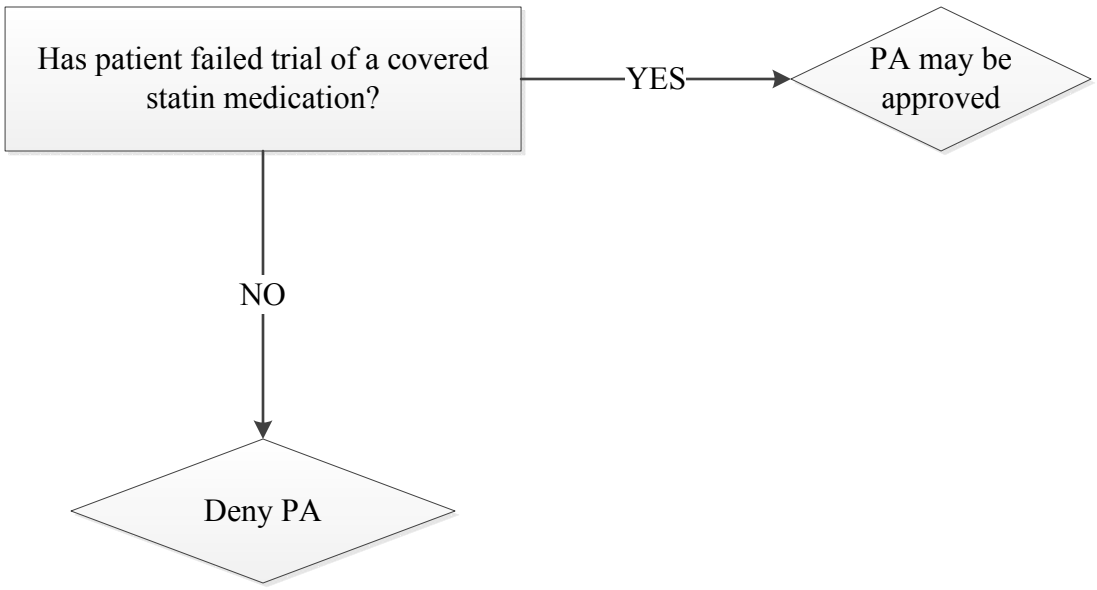
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Livalo Authorization Algorithm



METOZOLV ODT 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 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: □ 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	

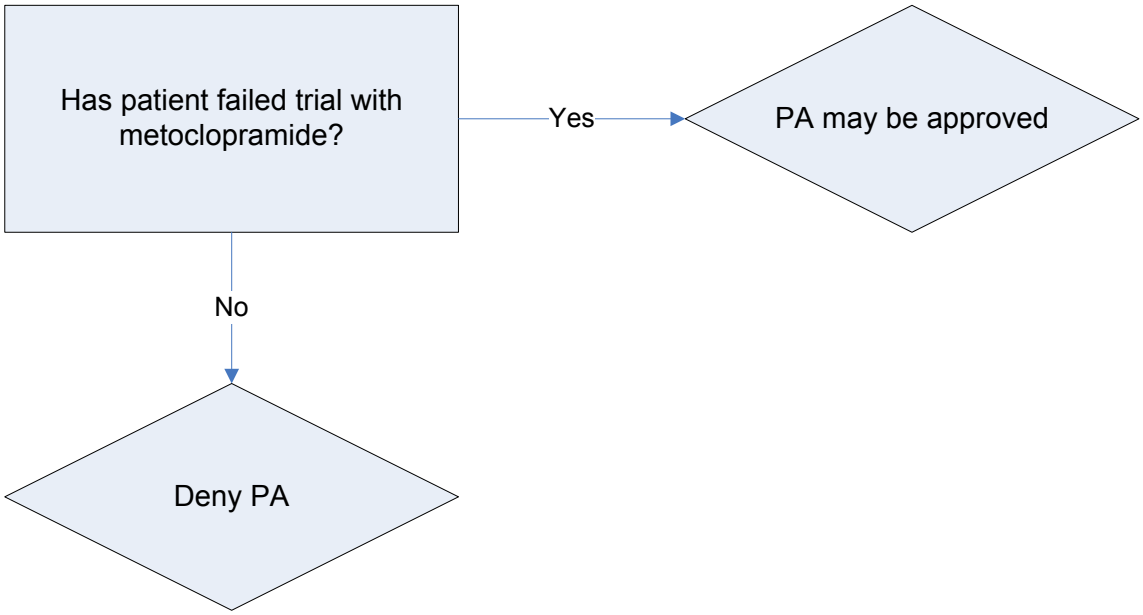
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Metozolv Prior Authorization Algorithm



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 : □ MOXATAG	**Dosage**
Qualifications for coverage:	
□ Allergic/intolerable side effects to inactive ingredients of regular-release amoxicillin. Name of inactive ingredient: _____	Diagnosis for this request:
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*	
Physician Signature	Date

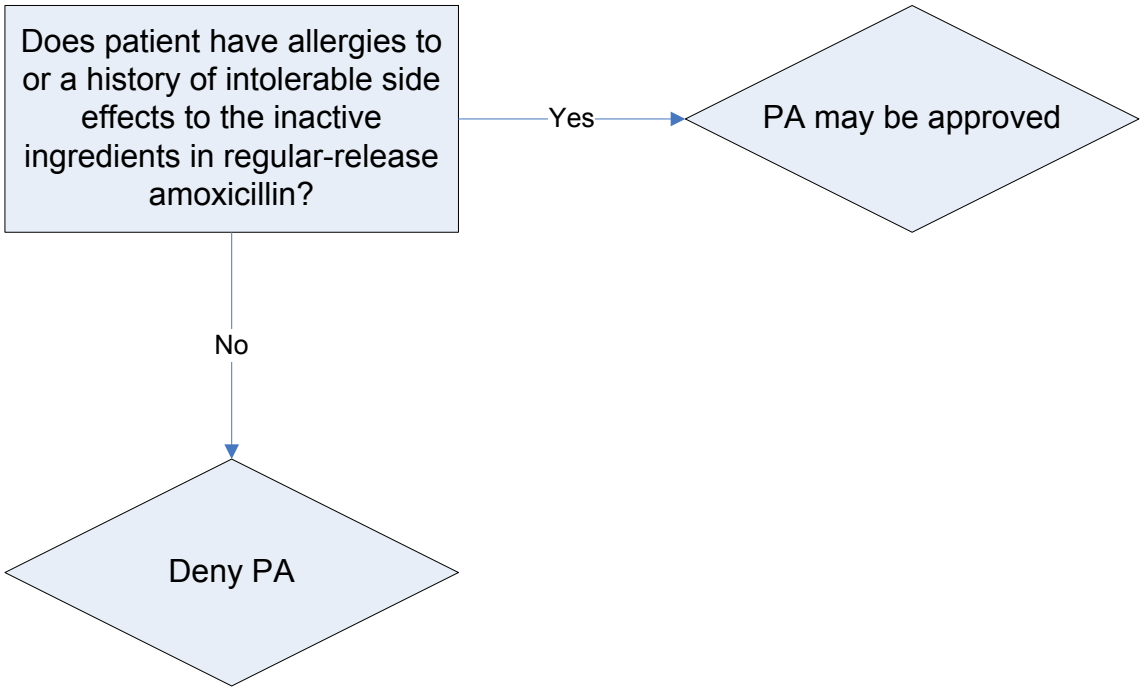
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Moxatag Authorization Algorithm



Regular-release amoxicillin does not require a prior authorization and costs approximately $4.40 for a course of therapy compared to $84.40 for a course of Moxatag therapy.

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:

□ Celebrex

□ Other _____

Diagnosis for this request:

□ Warfarin/Corticosteroid therapy

□ Gastric or duodenal ulcer

□ Actinic keratoses **(Solaraze)**

□ GI bleed, perforation or obstruction

□ Endoscopically documented NSAID gastritis with GI Bleed

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

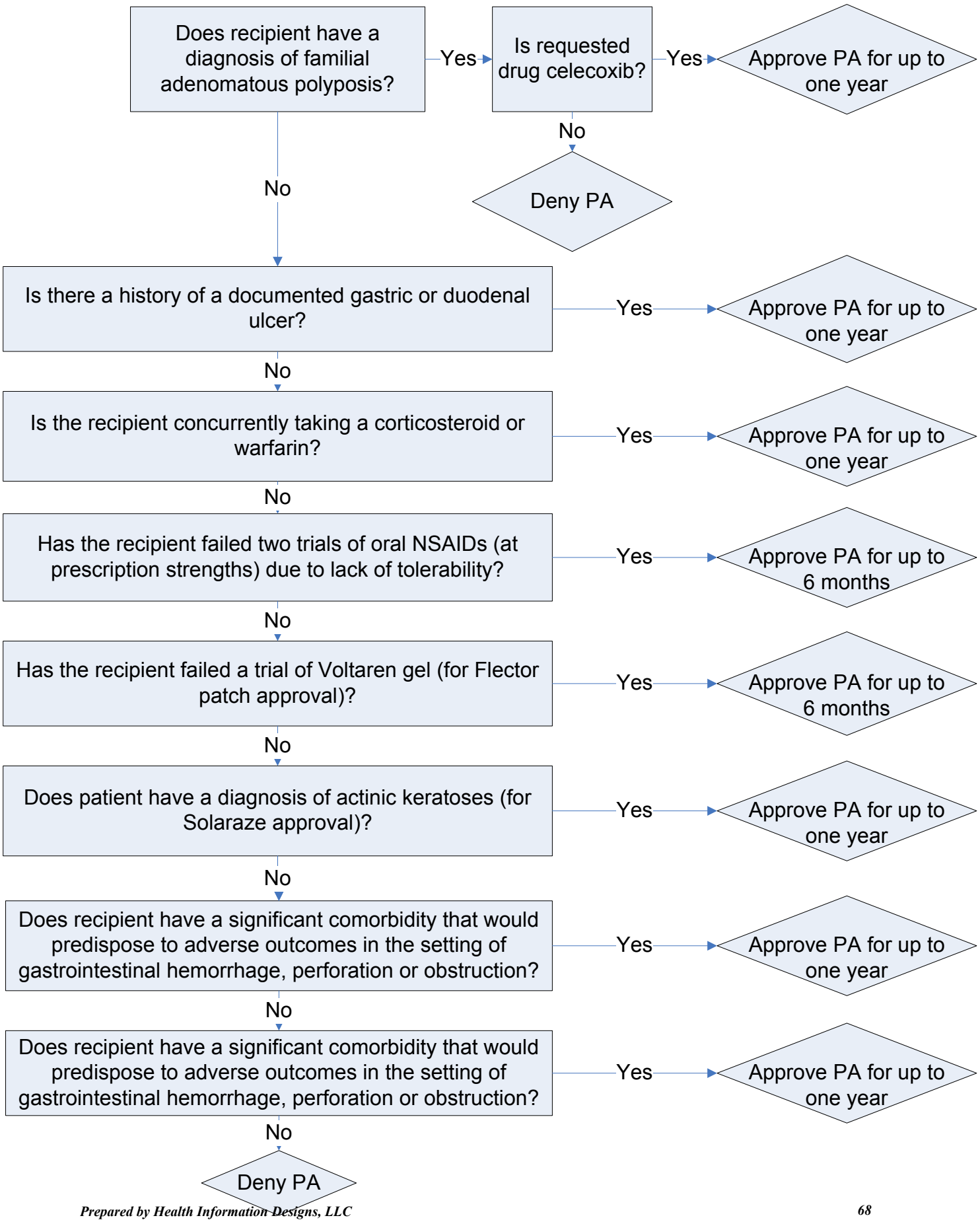
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

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



BRAND-NAME NARCOTICS 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 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

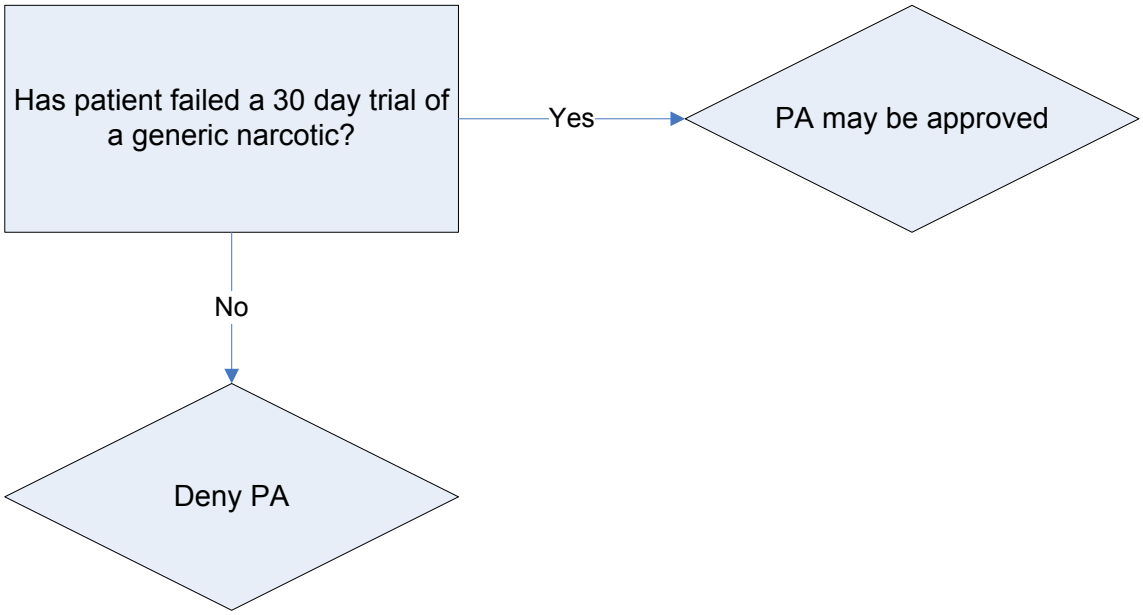
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Name-brand Narcotics Prior Authorization Algorithm



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 START DATE: END DATE:	DOSE: 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 - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

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: □ **Nexiclon**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED CLONIDINE THERAPY START DATE: END DATE:	DOSE: FREQUENCY:		
Physician Signature		Date	

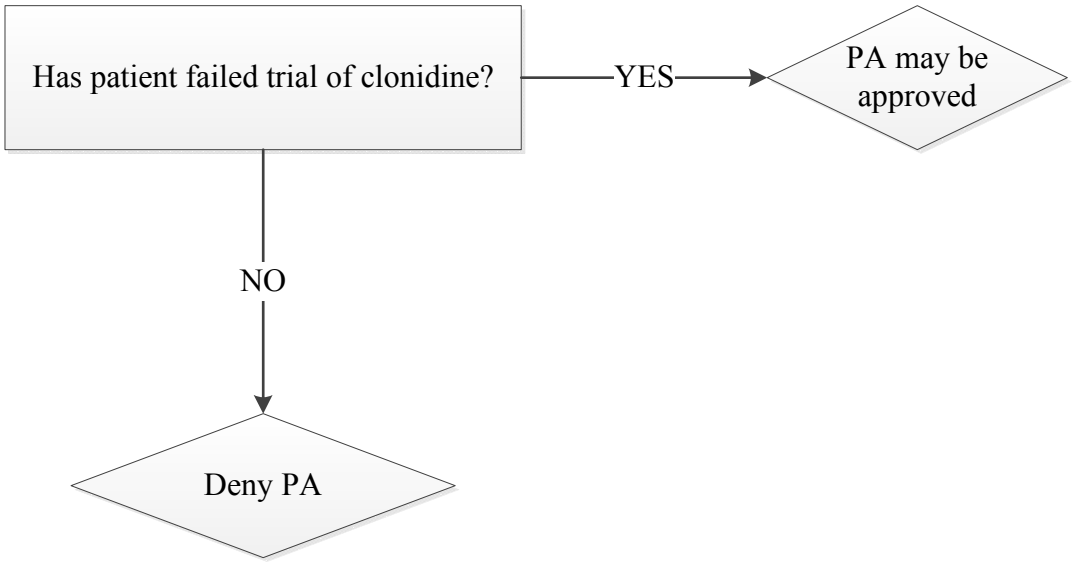
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Nexiclon Authorization Algorithm



Nucynta Prior Authorization

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 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: □ **Nucynta**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ UNABLE TO TOLERATE OTHER OPIOIDS DUE TO GASTROINTESTINAL SIDE EFFECTS OPIOID TRIED_____ START DATE: DOSE: END DATE: FREQUENCY:			
Prescriber Signature		Date	

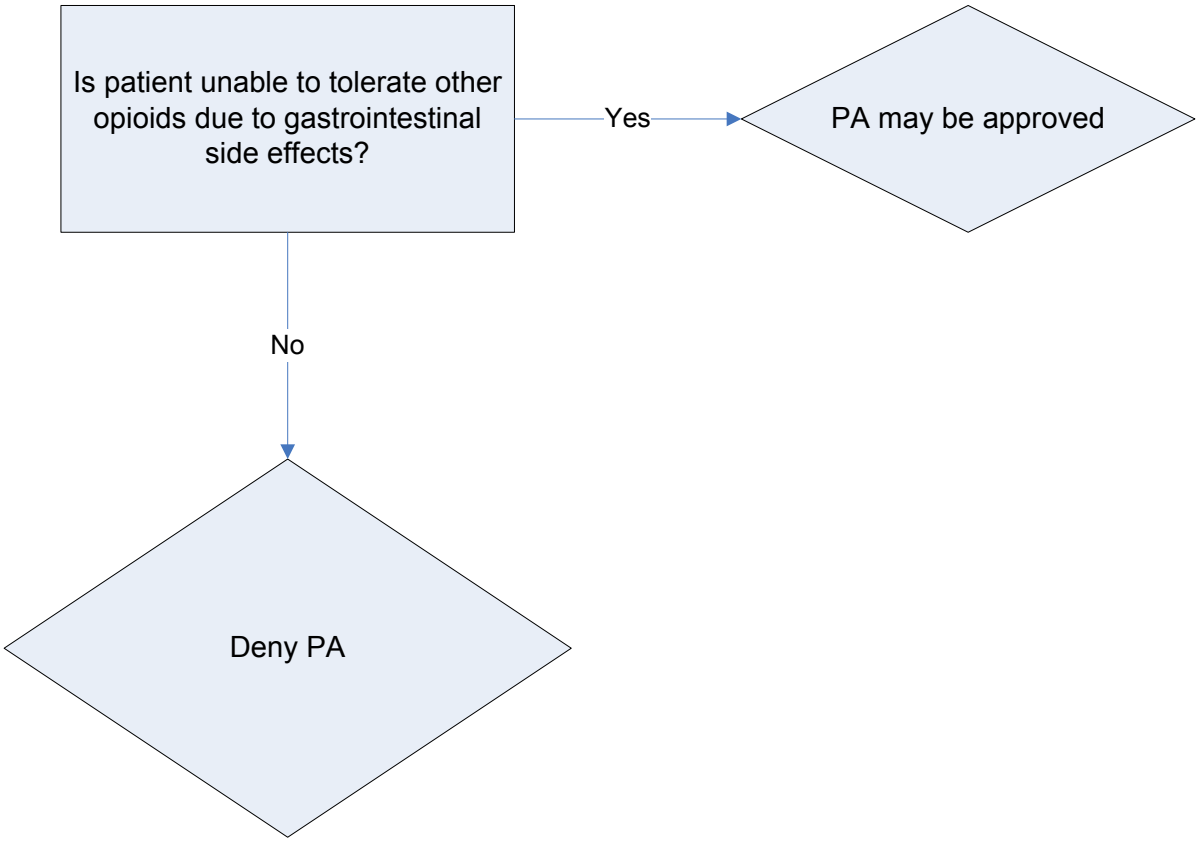
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Nucynta Authorization Algorithm



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: □ **Nuedexta**	**Diagnosis for this request (must check at least 2):** □ **PBA** □ **ALS** □ **MS**		
Physician Signature		Date	

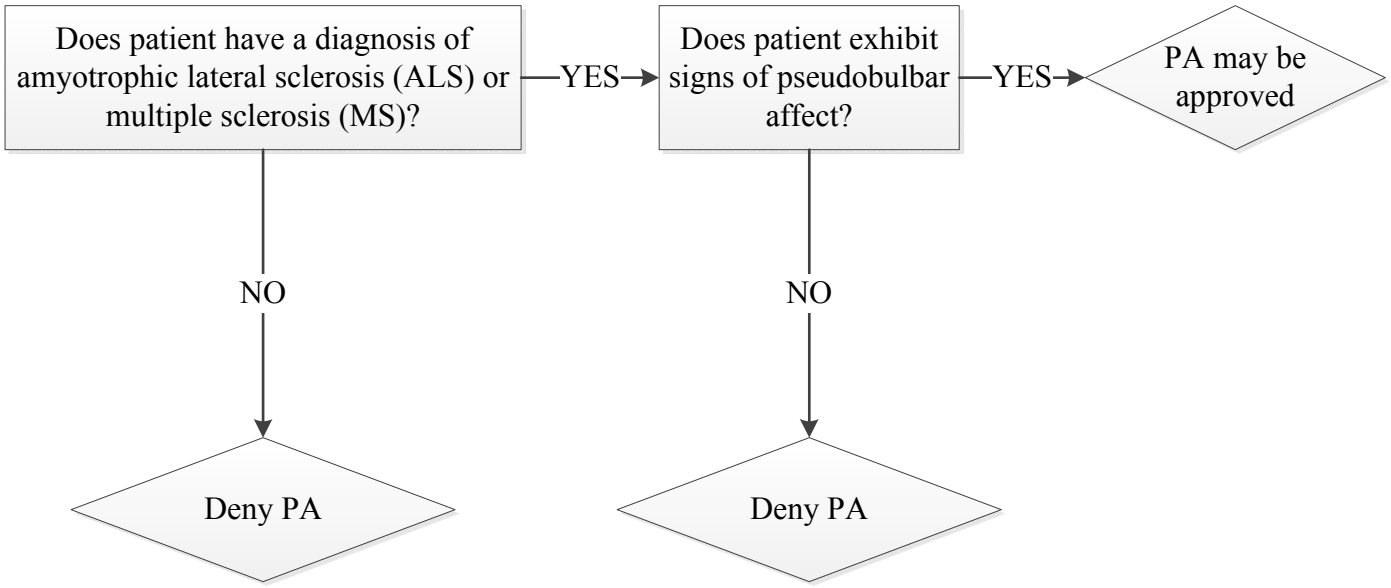
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Nuedexta Authorization Algorithm



HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

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 Nuvigil must suffer from excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome, narcolepsy, or shift work disorder.

- **Provigil 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: □ **Nuvigil**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED PROVIGIL (MODAFINIL)	START DATE: END DATE:	DOSE: FREQUENCY:	
□ EXCESSIVE SLEEPINESS ASSOCIATED WITH OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME □ NARCOLEPSY □ SHIFT WORK SLEEP DISORDER			
Prescriber Signature		Date	

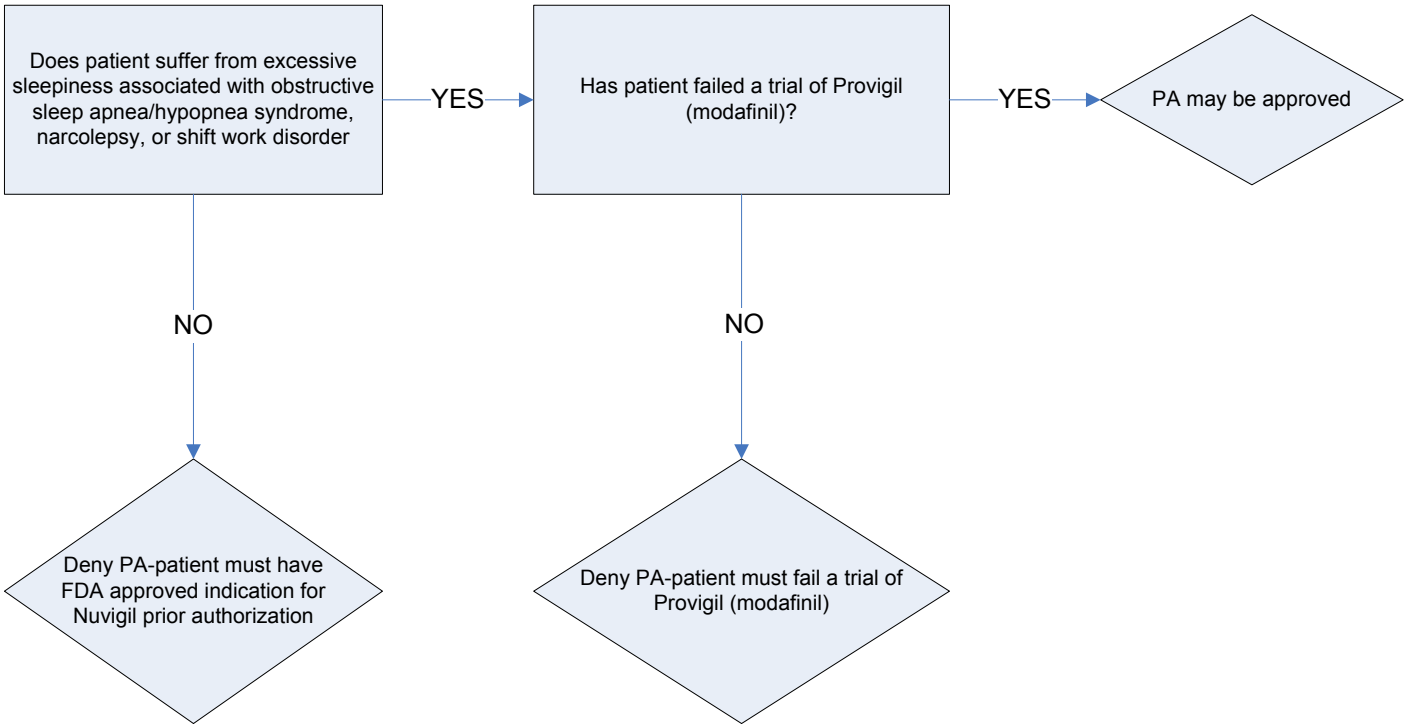
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Nuvigil Authorization Algorithm



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 □ Medication Failed _____	Start Date: End Date:	Dose: Frequency:	
Physician Signature		Date	

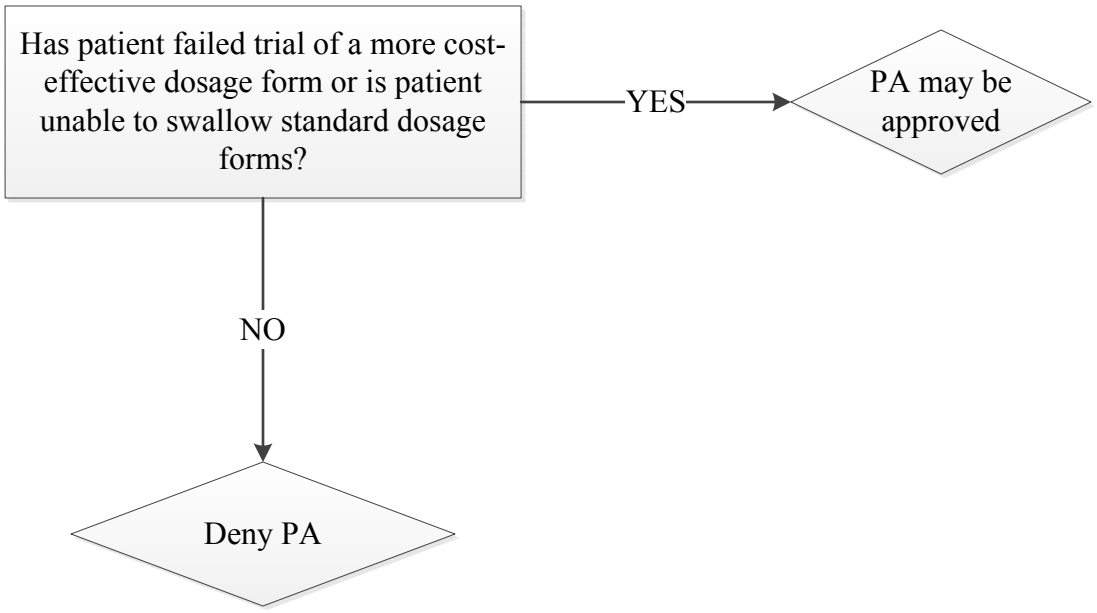
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Orally Disintegrating Tablets (ODT) Authorization Algorithm



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: □ **Lastacaft** □ **Bepreve** □ **Pataday**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED THERAPY START DATE: END DATE:	DOSE: FREQUENCY:		
Physician Signature		Date	

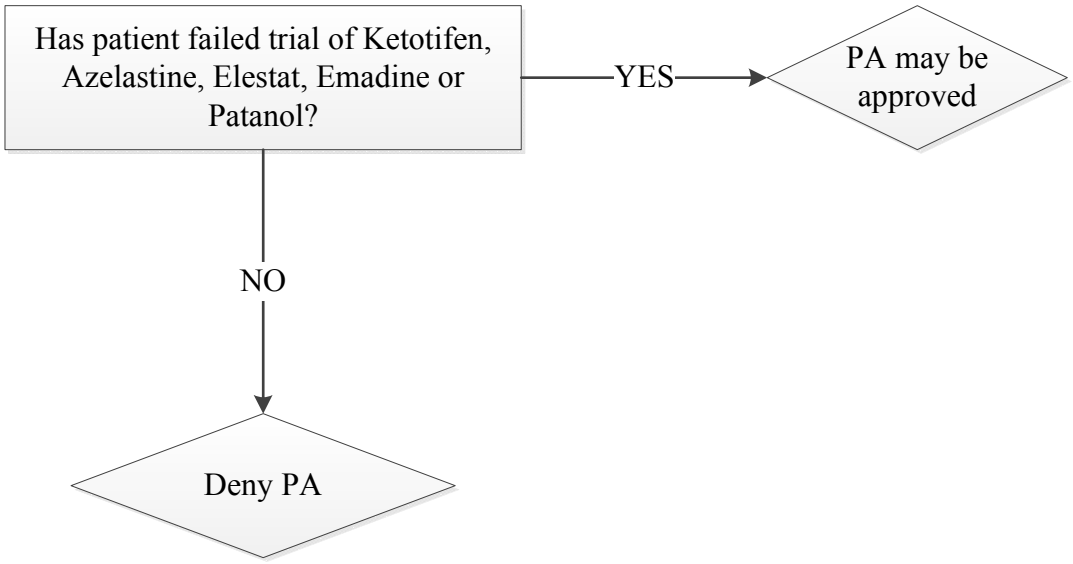
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Ophthalmic Antihistamine Authorization Algorithm



OPHTHALMIC ANTI-INFECTIVE 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 will not pay for Azasite or Quixin 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: □ AZASITE □ 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		

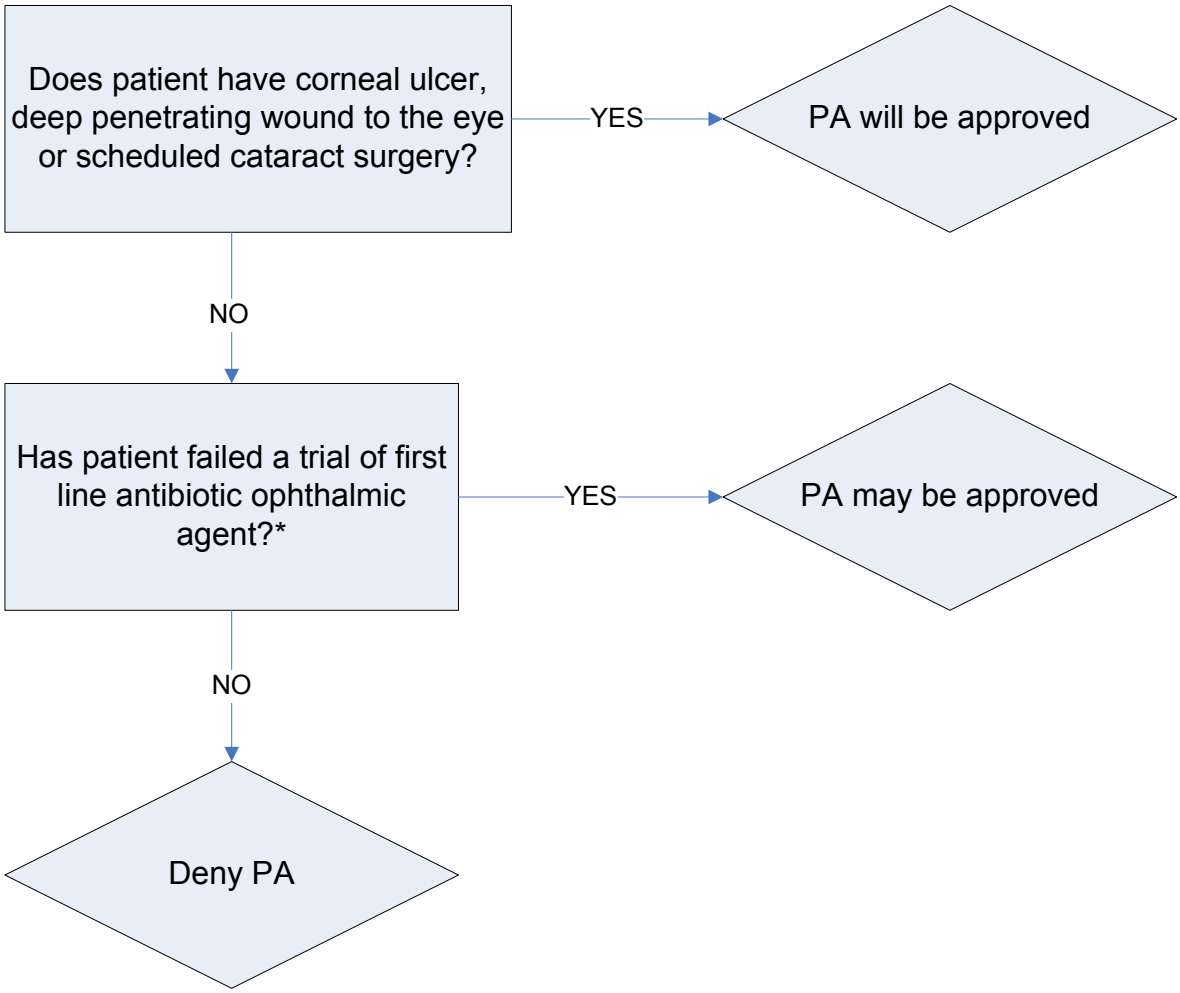
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

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



*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).

HEALTH INFORMATION DESIGNS

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: □ **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:

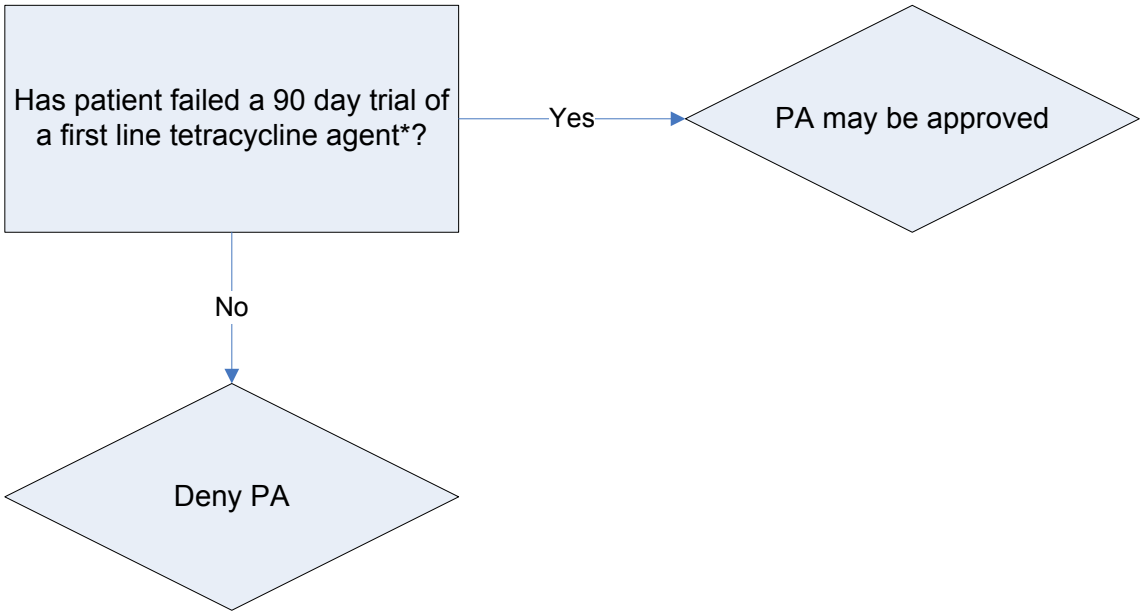
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Doryx and Oracea Prior Authorization Algorithm



**Doxycycline, minocycline, and tetracycline do not require a PA and cost approximately $3 - $40 for a course of therapy compared to $353 dollars for Oracea and $331 dollars for Doryx.

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 or Xarelto 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: □ PRADAXA □ XARELTO	**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	

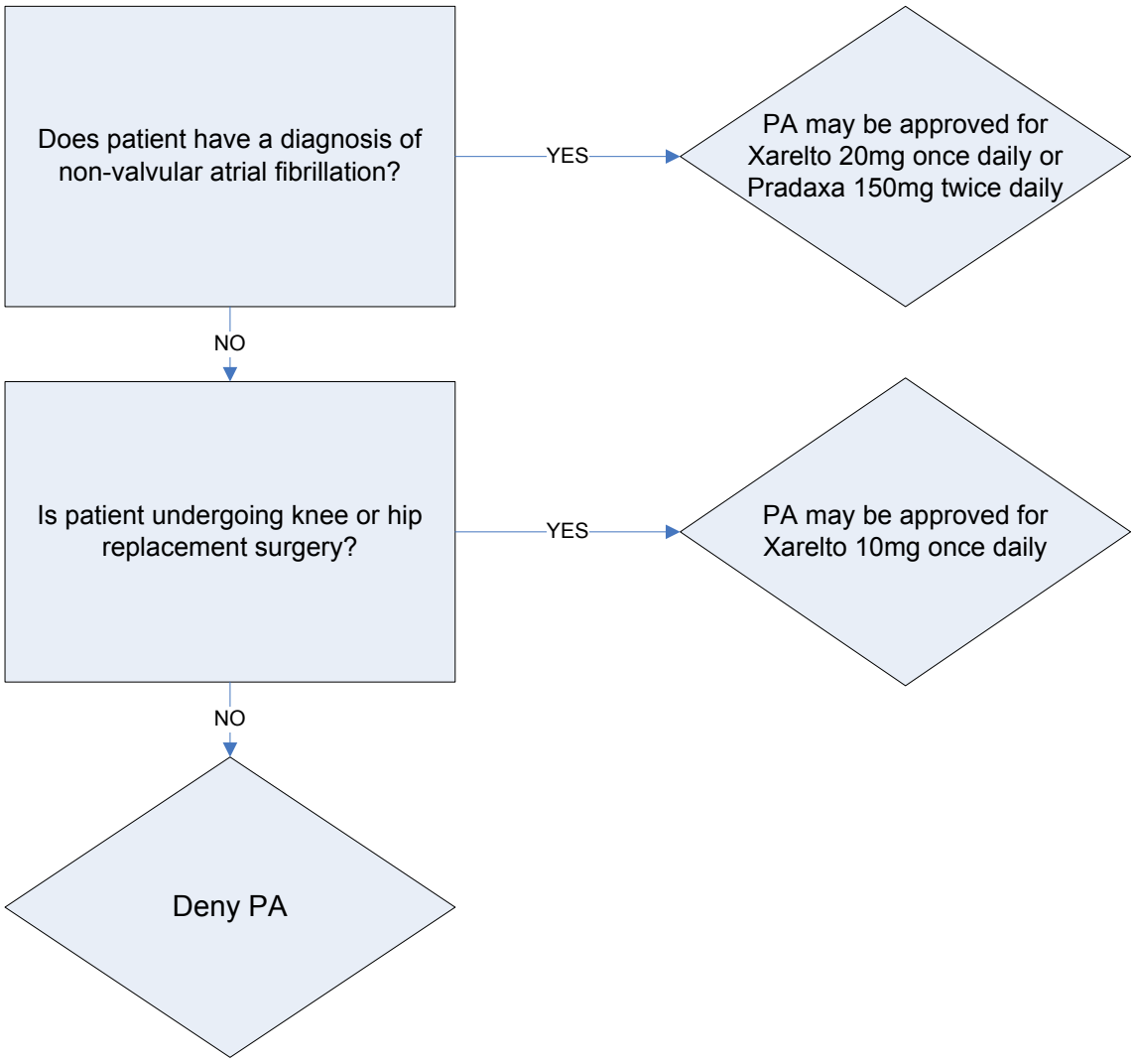
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Oral Anticoagulants Prior Authorization Algorithm



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: □ **Oravig**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ **Medication failed** _____	**Start Date:** **End Date:**	**Dose:** **Frequency:**	
Physician Signature		Date	

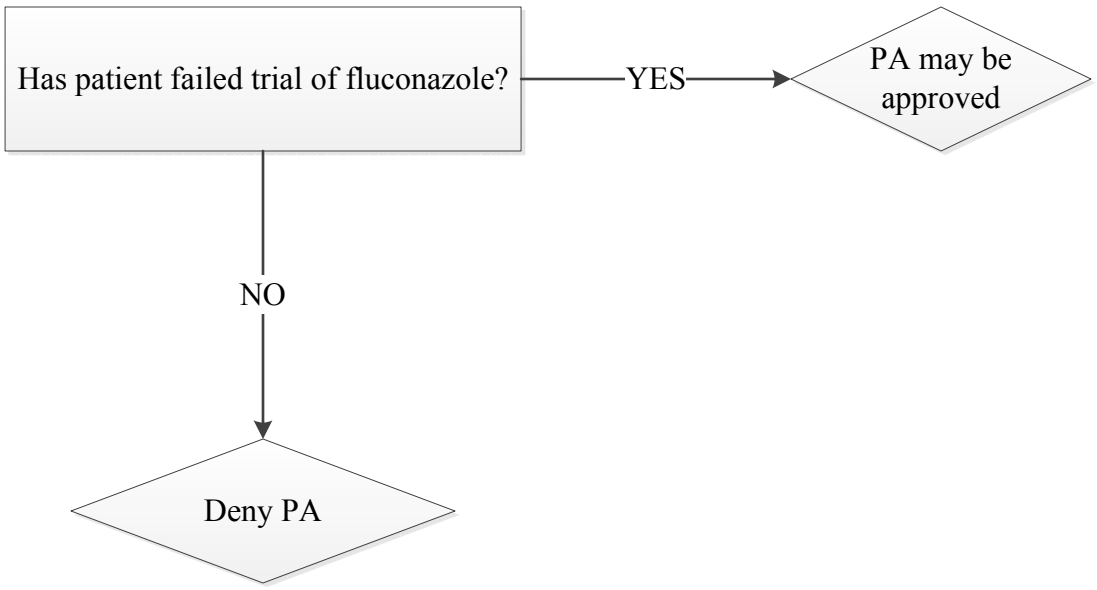
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Oravig Authorization Algorithm



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: □ OXYCODONE CR	**DOSAGE:**	**Diagnosis for this request:**	
QUALIFICATIONS FOR COVERAGE: □ CHRONIC MALIGNANT PAIN INDICATION □ 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

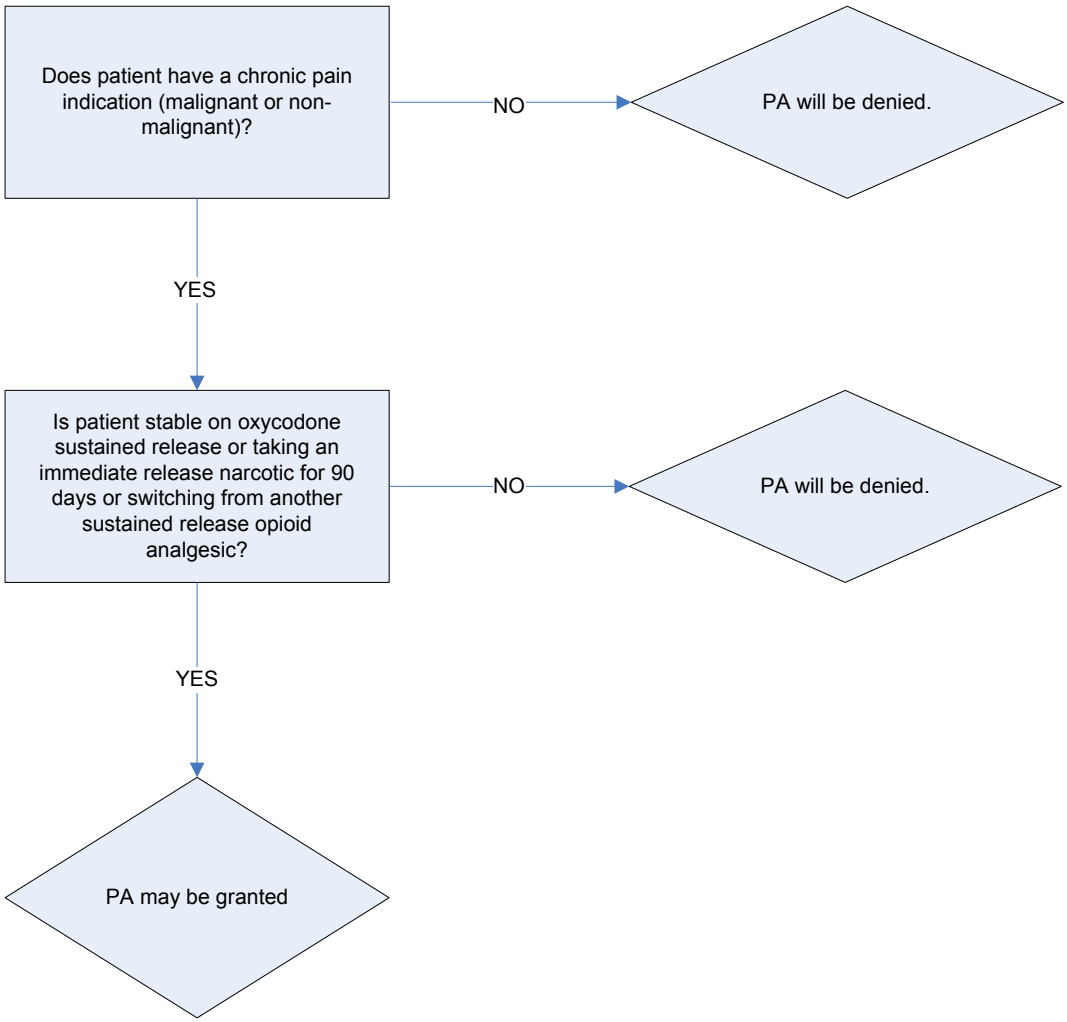
PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services

Oxycodone CR Prior Authorization Criteria Algorithm



PRIOR AUTHORIZATION REQUEST

ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
SFN 1115 (7-2006)

– Please refer to Pharmacy and Durable Medical Equipment Manuals for current prior authorization requirements.

ND Department of Human Services
Medical Services
600 E Boulevard Ave Dept 325
Bismarck ND 58505-0261
701-328-4030

Clear Fields

INSTRUCTIONS: PLEASE READ BACK FOR INSTRUCTIONS.

Patient's Name: Last	First	Middle	Date of Birth:	Client I.D. Number:
Patient's Address:				
Patient's Residence: ☐ NF/Swing Bed ☐ ICF/MR ☐ Basic Care ☐ Private Care				

I. TO BE COMPLETED BY PHYSICIAN

Item Prescribed:	Diagnosis & Prognosis **(Numeric Code)**:
Explanation of Medical Necessity, Duration of Need and Date of Visit:	

I certify that the above-prescribed durable medical equipment/supplies/medication is medically necessary for this patient's well being. In my opinion, this is reasonable and necessary in conformance with accepted standards of medical practice for the treatment of this condition. This has not been prescribed as a convenience to the patient.

Physician's Name: (Please Print)	Provider Number:	Physician's Signature:	Date:

II. TO BE COMPLETED BY PROVIDER (SUPPLIER)

Provider's Name:	Provider's Number:	Telephone Number:	
Provider's Street Address:	City:	State:	Zip Code:
Provider Signature:			Date:

PROPOSED MEDICAL EQUIPMENT OR SUPPLIES						STATE USE ONLY	
HCPC/NDC CODE	List: Item, make/model, units or days, quantity per case, and number of days supply hours/minutes of labor/evaluations. Continue on another page of form if necessary.	**DATE(S) OF SERVICE START/STOP**	**CUSTOMARY OR USUAL RETAIL**	**ACQUISITION COST**	**MOS. OF RENTAL/ QTY PRESCRIBED**	**MAXI REIM**	**APPR DENY**
	1)	Start					
Comments:		Stop					
	2)	Start					
Comments:		Stop					
	3)	Start					
Comments:		Stop					
	4)	Start					
Comments:		Stop					
	5)	Start					
Comments:		Stop					

I acknowledge that the approval of this request does not guarantee the eligibility of the recipient nor ensure payment for services. I understand that eligibility is established by the appropriate county social service board monthly and payment is contingent upon eligibility at the time the service is provided. I also understand that payment for such services may be denied unless prior approval is obtained.

REMARKS: (STATE USE ONLY)

DISTRIBUTION: Original - Submit to Medical Services for approval, a computer printed notice with the assigned request number and approval/denial will be returned. The number must be placed on the claim for payment.

INSTRUCTION FOR COMPLETION:

Section I - To be completed by the prescribing physician, provider name and physician signature are required. Justification for approval or denial of the medical equipment or supplies will be based upon this information. Along with the diagnosis, a comprehensive explanation of MEDICAL NECESSITY must confirm the prescription.

Section II - To be completed by the **provider (supplier)** of service. Complete name, address, telephone number and provider number should be entered. The proposed medical equipment/supplies/or medication to be described and listed separately. The description must be complete enough for the Department of Human Services to verify your customary or usual retail charge; acquisition cost must be indicated for all items (See DMEOPS Manual for rental specifics.) Upon completion, provider should **mail the original copy only** to: Medical Services, Department of Human Services, 600 East Boulevard Avenue, Bismarck, ND 58505-0261.

PRIOR AUTHORIZATION PROCESS:

1. The Department of Human Services will review, approve/deny, and key the request. A computer generated response with an assigned prior authorization number will be returned to the provider.

2. Upon approval, HCFA 1500 billers should enter the assigned prior approval number on the claim form before submitting to Medical Services for payment. The assigned prior approval number should **not** be submitted on pharmacy point-of-sale claims as the claims edit process locates and inserts the prior approval number electronically. Date(s) of Service must be indicated when submitting claims to this department for payment.

The Maximum Reimbursement listed is based on North Dakota Medical Services' fee. If other payor's/insurance is involved in the settlement of this claim, the Department of Human Services will abide by other payor's/insurance adjudication and accept other payor's/insurance allowable amount if different than the amount listed and adjudicate payment of deductible(s) and coinsurance amount(s).

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.**
- **Prior Authorization is NOT required for patients < 13 years of age.**
- **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: □ Aciphex □ Lansoprazole □ Nexium □ Zegerid □ Dexilant	**Requested Dosage:** (must be completed) **Diagnosis for this request:**

Qualifications for coverage:

❑ Failed Prilosec OTC/Prevacid 24HR/Omeprazole/Pantoprazole therapy	Start Date: End Date:	Dose: Frequency:
□ Pregnancy – Due Date		
□ Inability to take or tolerate oral tablets (must check a box) □ Tube Fed □ Requires soft food or liquid administration □ Other (provide description)		
□ Adverse reaction (attach FDA Medwatch form) to omeprazole/lansoprazole.		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*		
Prescriber Signature:		Date:

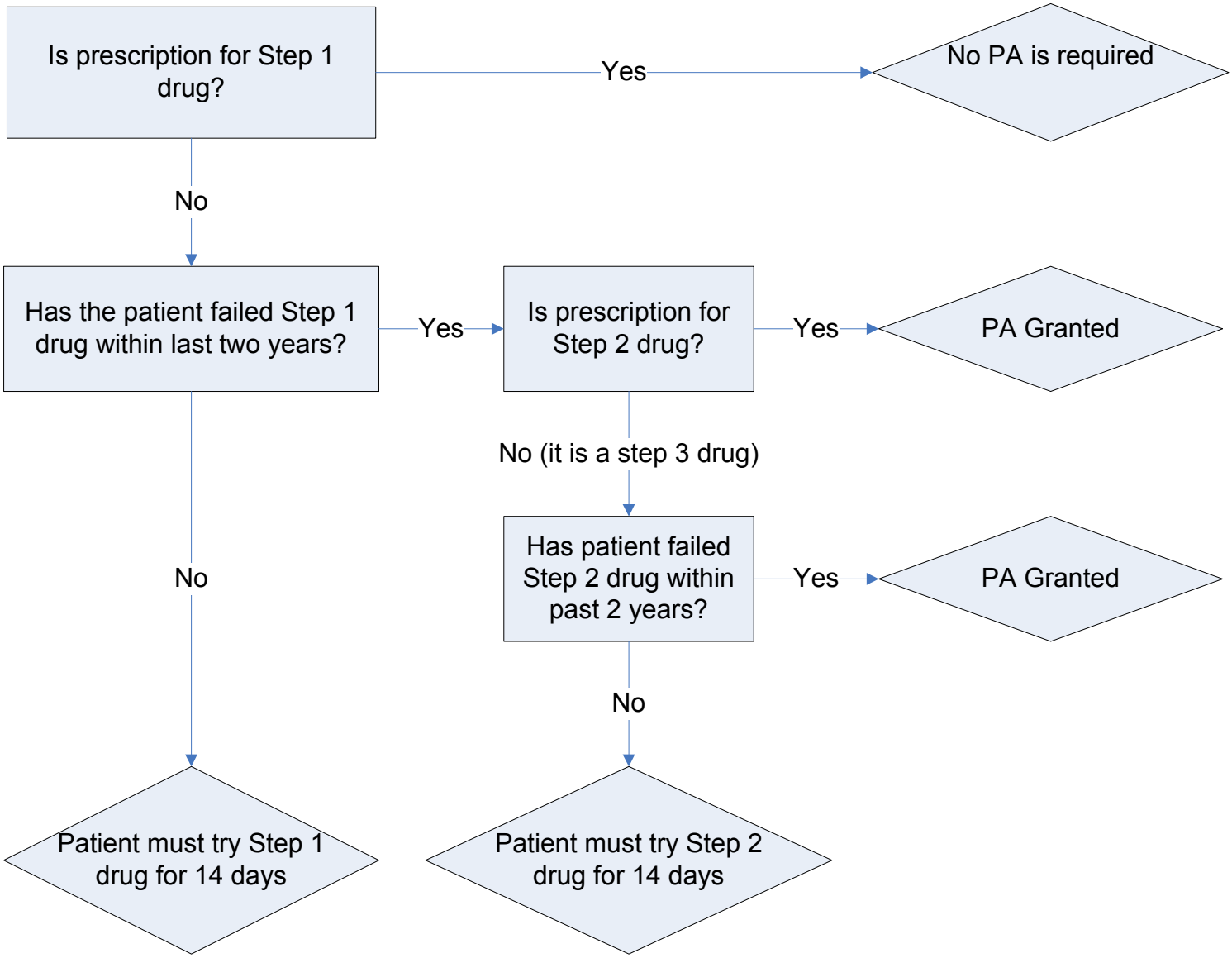
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Proton Pump Inhibitor Authorization Criteria Algorithm



Please Note:

Step 1 drug is defined as Prilosec OTC, Prevacid 24HR, omeprazole, and pantoprazole

Step 2 drug is defined as lansoprazole

Step 3 drug is defined as Nexium, Aciphex, Zegerid and Dexilant (which is 5-8 times more expensive)

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: ☐ **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:

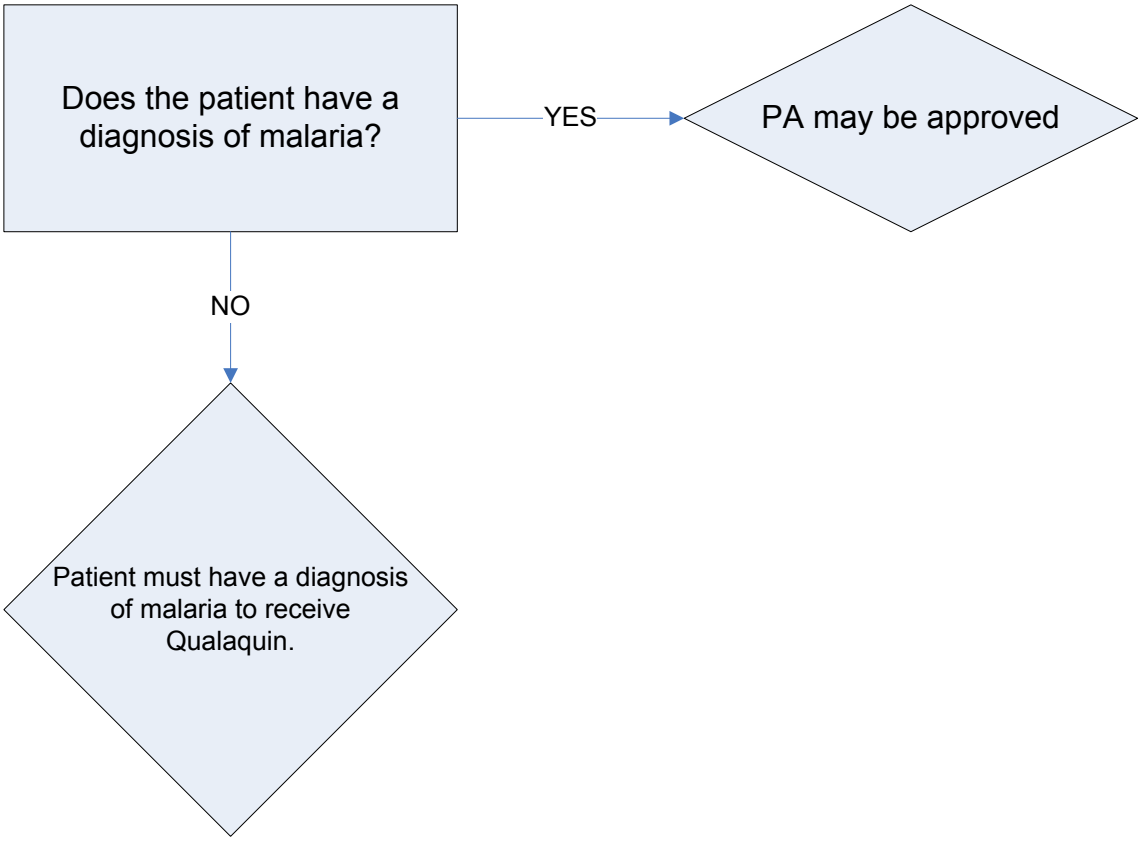
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Qualaquin Criteria Algorithm



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: □ **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	

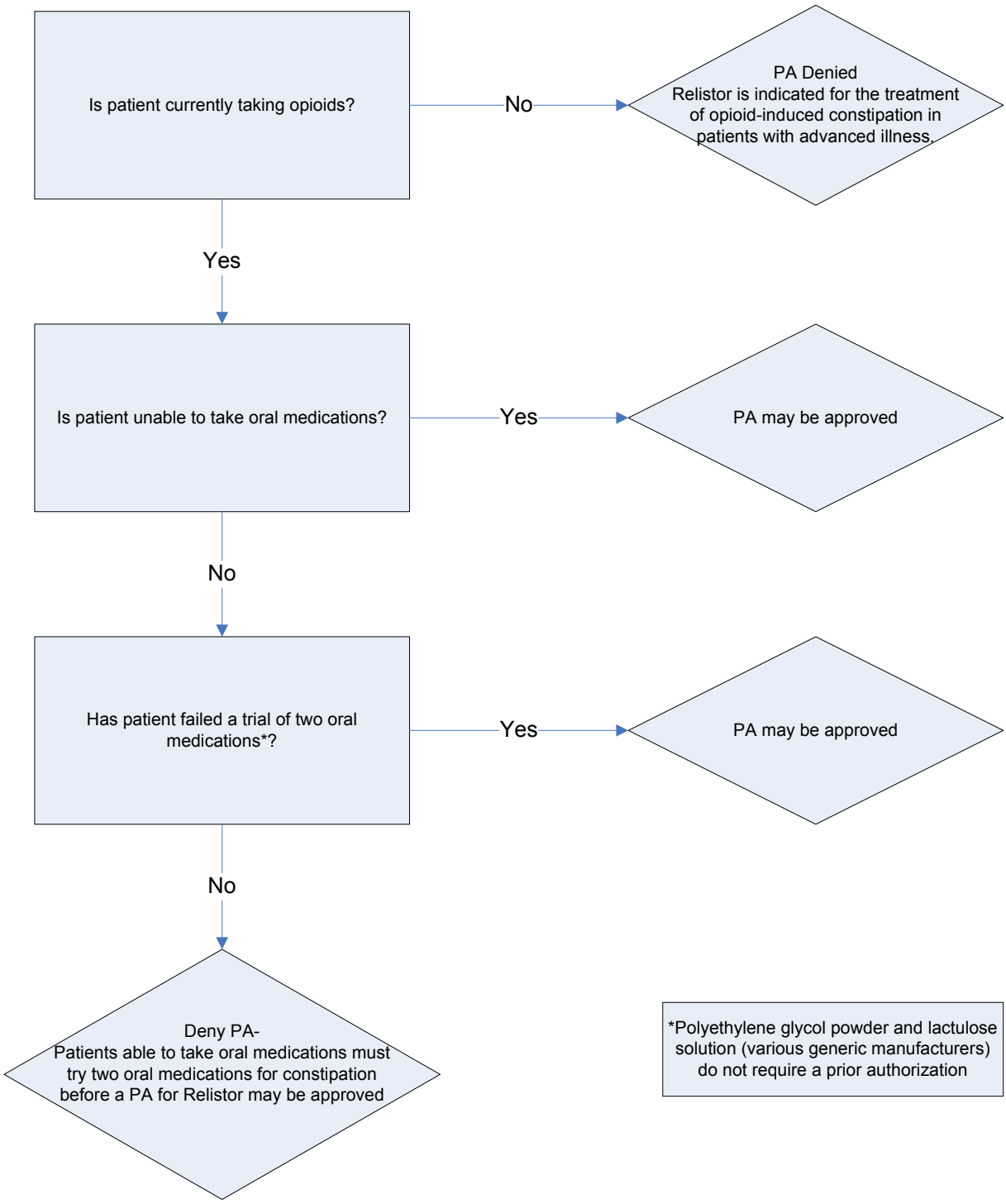
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Relistor Authorization Algorithm



Revatio/Adcirca
Prior Authorization 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 Revatio or Adcirca must have a diagnosis of Pulmonary Arterial Hypertension based on WHO (Group I) Classification for Pulmonary Hypertension.

****Note:***

- ***Patients taking Nitrates or Viagra/Levitra/Cialis will not receive a PA***

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber Medicaid Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: ☐ **Revatio** ☐ **Adcirca**	**Diagnosis for this request:**		
Qualifications for coverage:			
☐ Indication for the treatment of Pulmonary Arterial Hypertension (WHO Group I Classification)			
Prescriber Signature	Date		

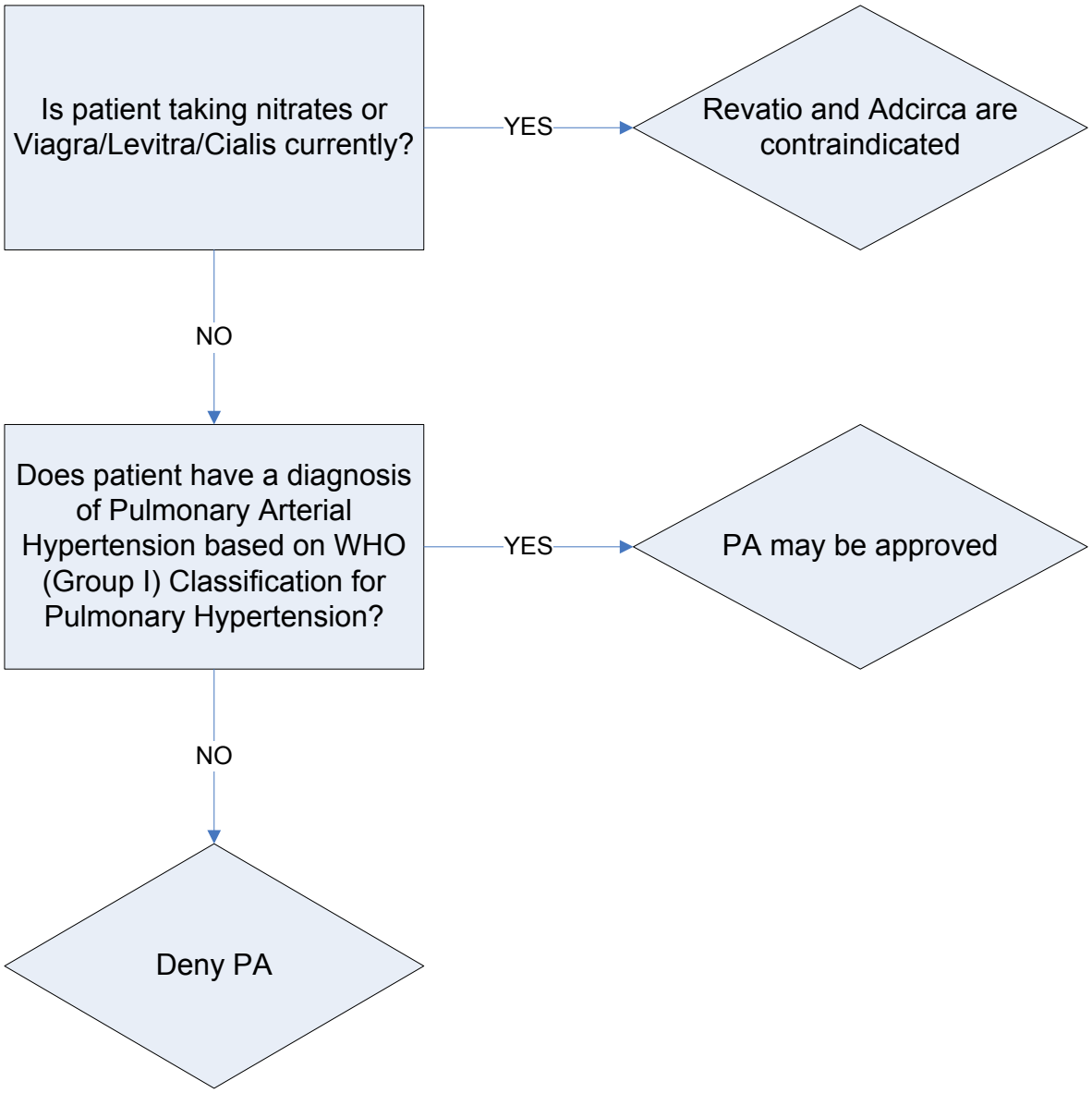
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Revatio/Adcirca Authorization Algorithm



RIBAPAK 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 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: □ 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		

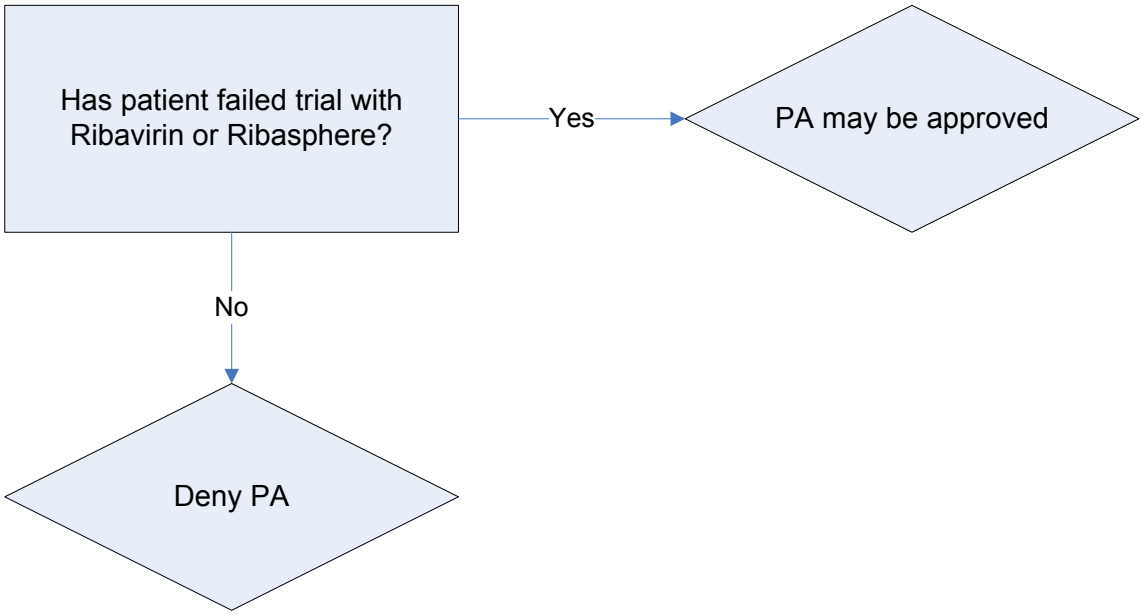
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Ribapak Prior Authorization Algorithm



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: □ **Sancuso**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED MEDICATION	START DATE: END DATE:	DOSE: FREQUENCY:	
□ PATIENT UNABLE TO TAKE ORAL MEDICATIONS			
Prescriber Signature		Date	

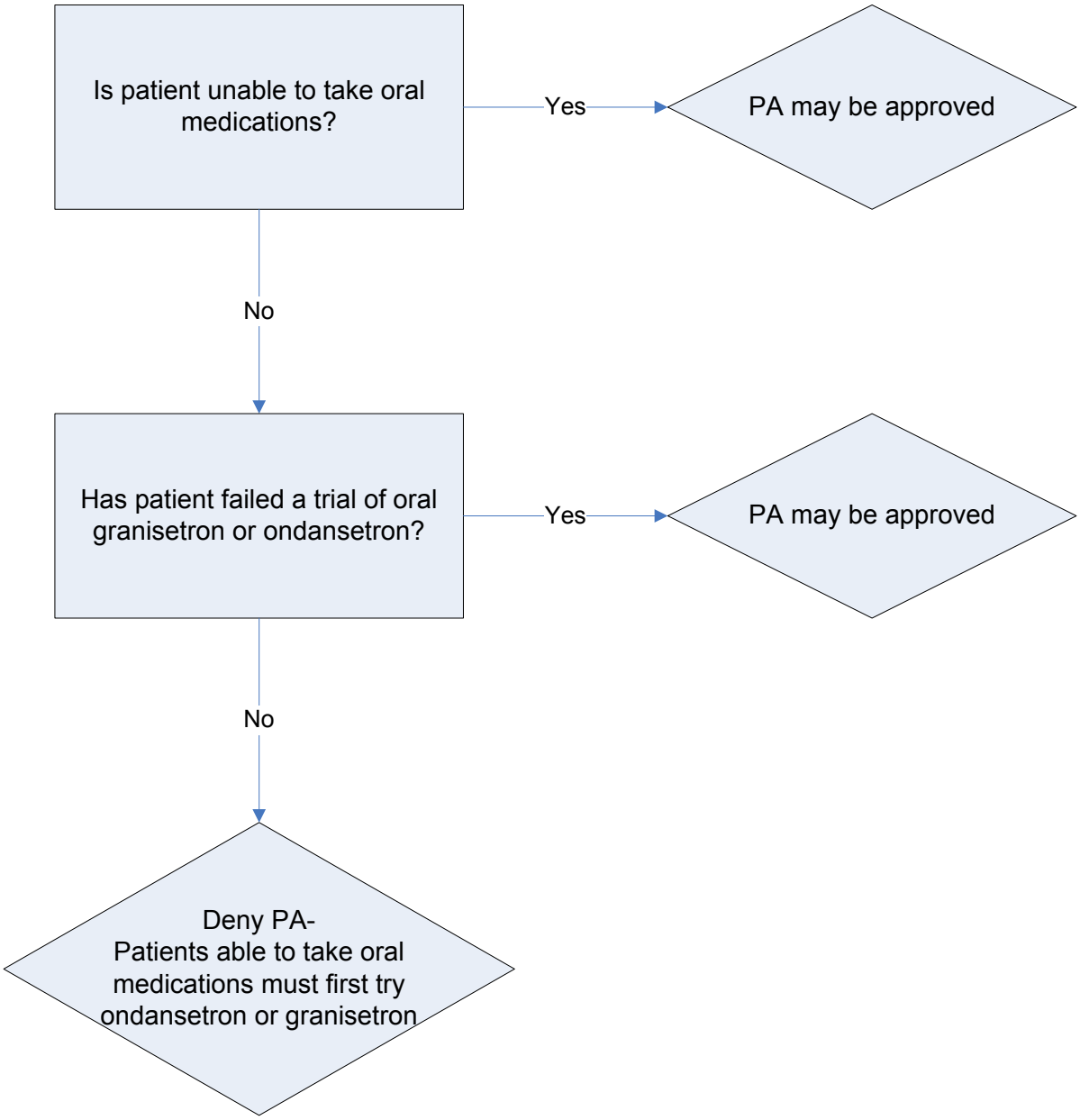
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Sancuso Authorization Algorithm



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: End Date:	Dose: 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	

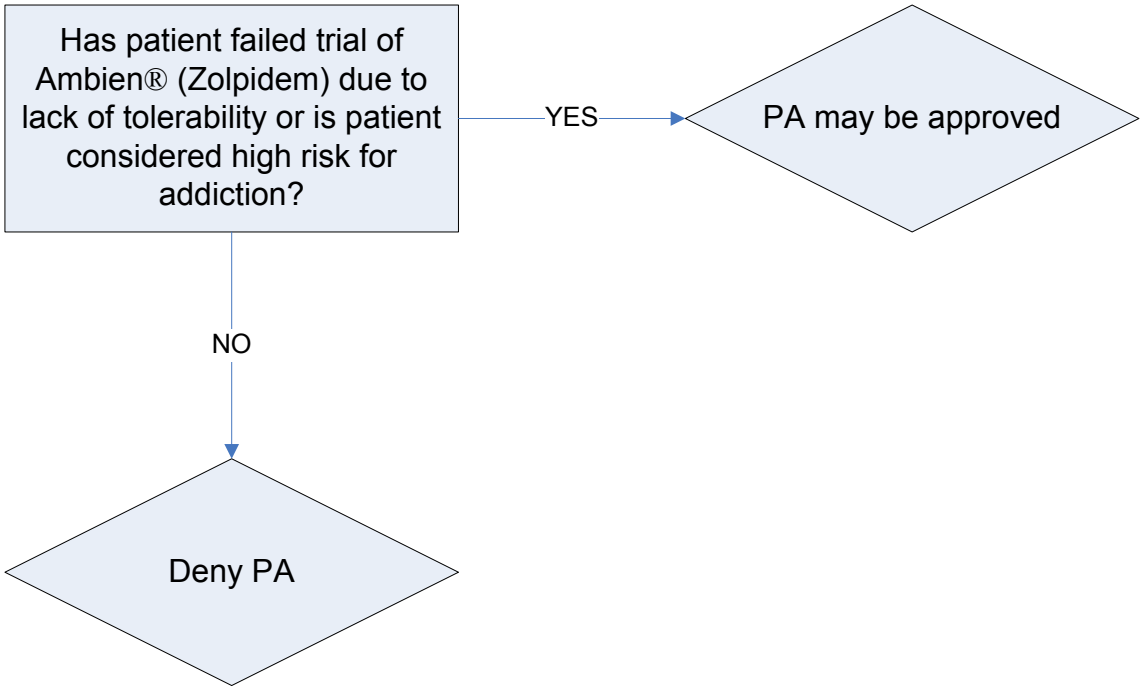
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Sedative/Hypnotic Authorization Algorithm



Short-Acting HFA Beta$_2$ Agonist 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 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: □ XOPENEX HFA □ VENTOLIN HFA □ 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

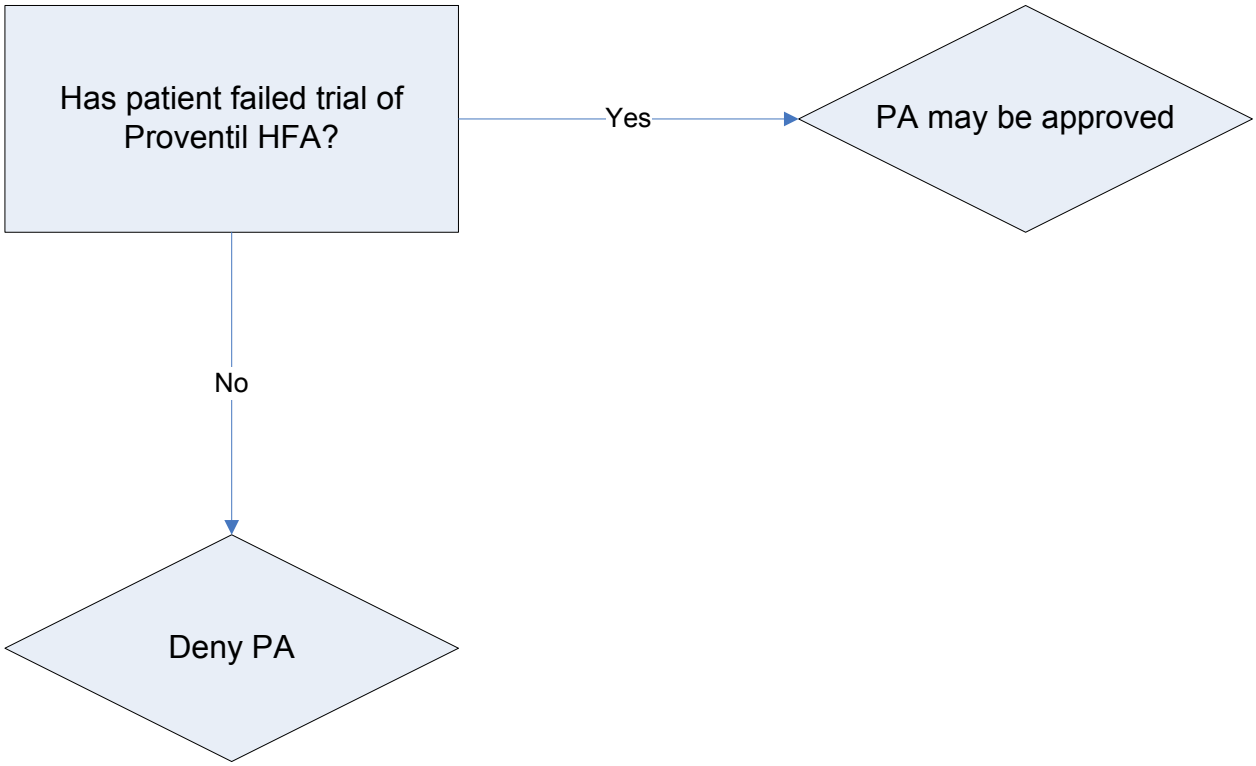
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services Short-Acting Beta$_2$ Agonist Authorization Algorithm



SOLODYN 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 Solodyn 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: □ **SOLODYN**	**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:

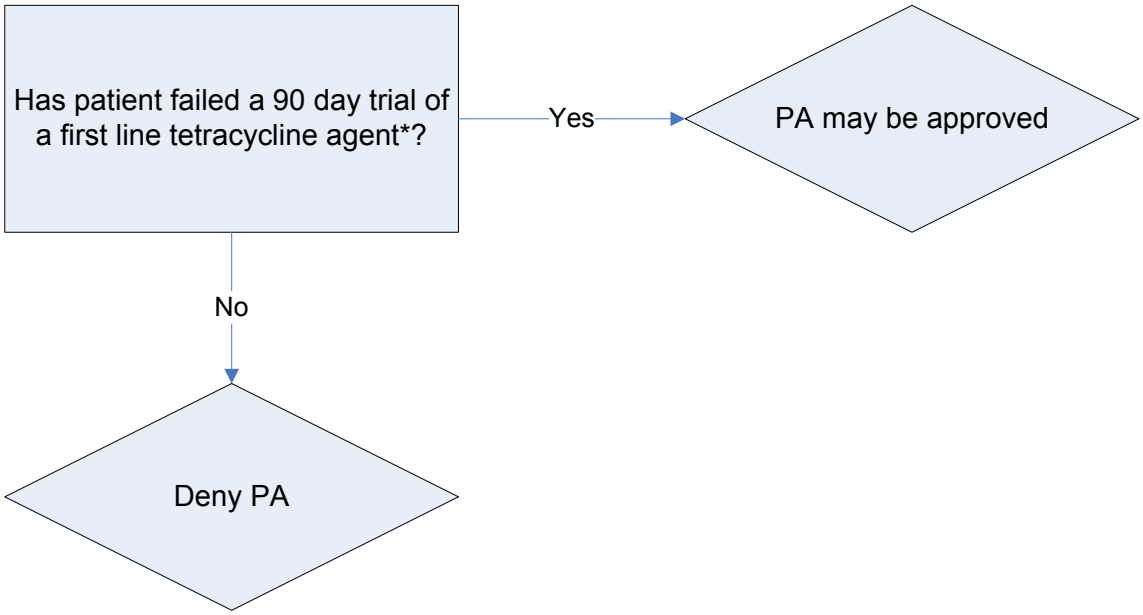
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Solodyn Prior Authorization Algorithm



*Doxycycline, minocycline, and tetracycline do not require a PA and cost approximately $3 - $40 for a course of therapy compared to $775 dollars for Solodyn.

SOMA 250mg 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 brand name Soma 250mg must use generic carisoprodol 350mg first line.

***Note: The PA will be approved if recipient fails a trial of carisoprodol 350mg.**

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: □ SOMA 250MG	**Diagnosis for this request:**		

Qualifications for coverage:

□ Failed skeletal muscle relaxant 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

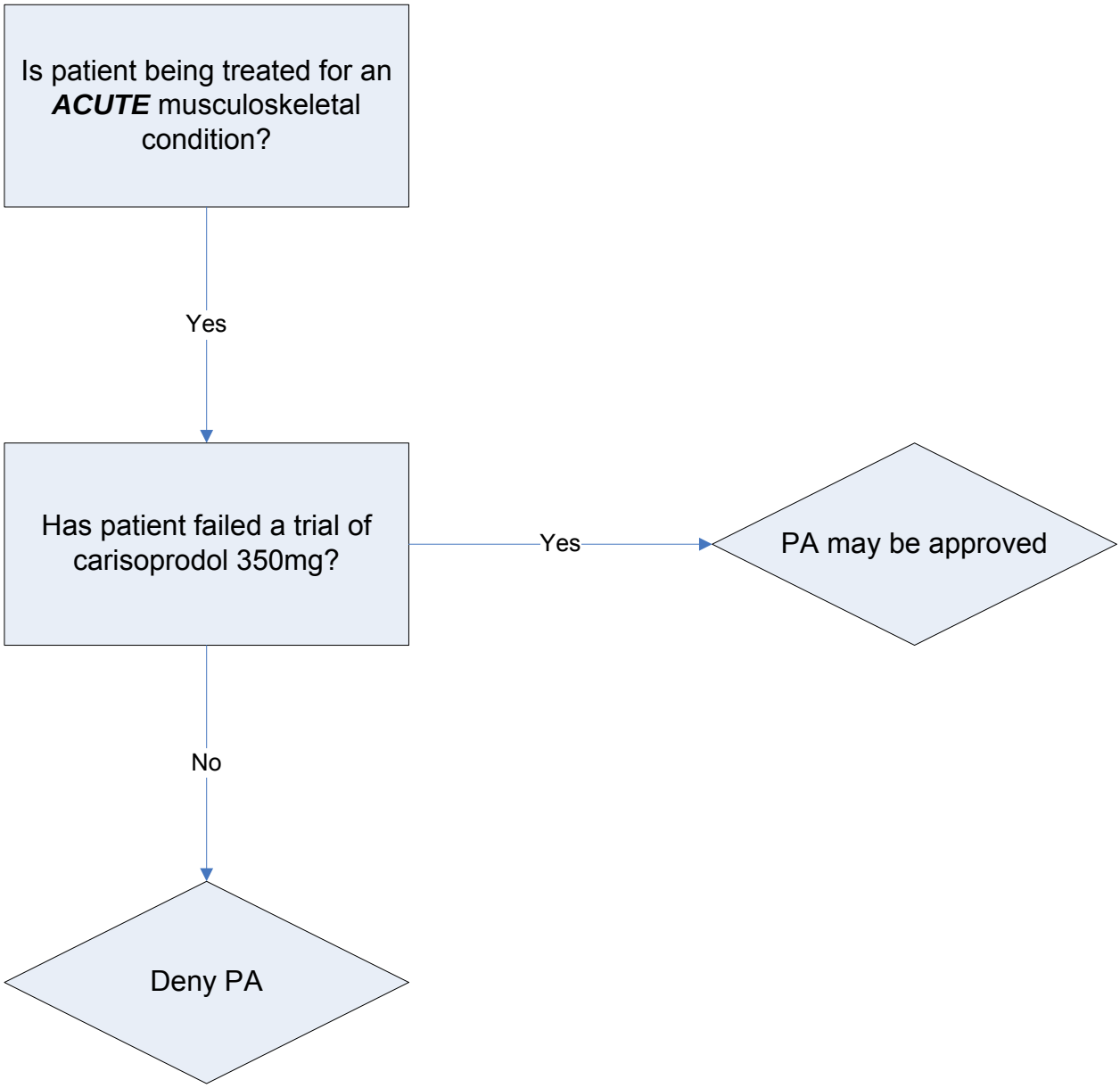
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Soma 250mg Authorization Algorithm



SUBOXONE/SUBUTEX 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 Suboxone and Subutex must meet the following criteria:

- **Patient must be 16 years or older.**
- **Indicated for use in treatment of documented opioid dependence.**
- **Must not be taking other opioids, tramadol, or carisoprodol concurrently.**
- **Prescriber must be registered to prescribe Suboxone/Subutex under the Substance Abuse and Mental Health Services Administration (SAMHSA).**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name	**(SAMHSA ID)**		
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ SUBOXONE □ SUBUTEX	**FDA Approved Indication for this request:**		
□ Patient is not taking other opioids, tramadol, or carisoprodol concurrently with Suboxone or Subutex.			
Physician Signature	Date		

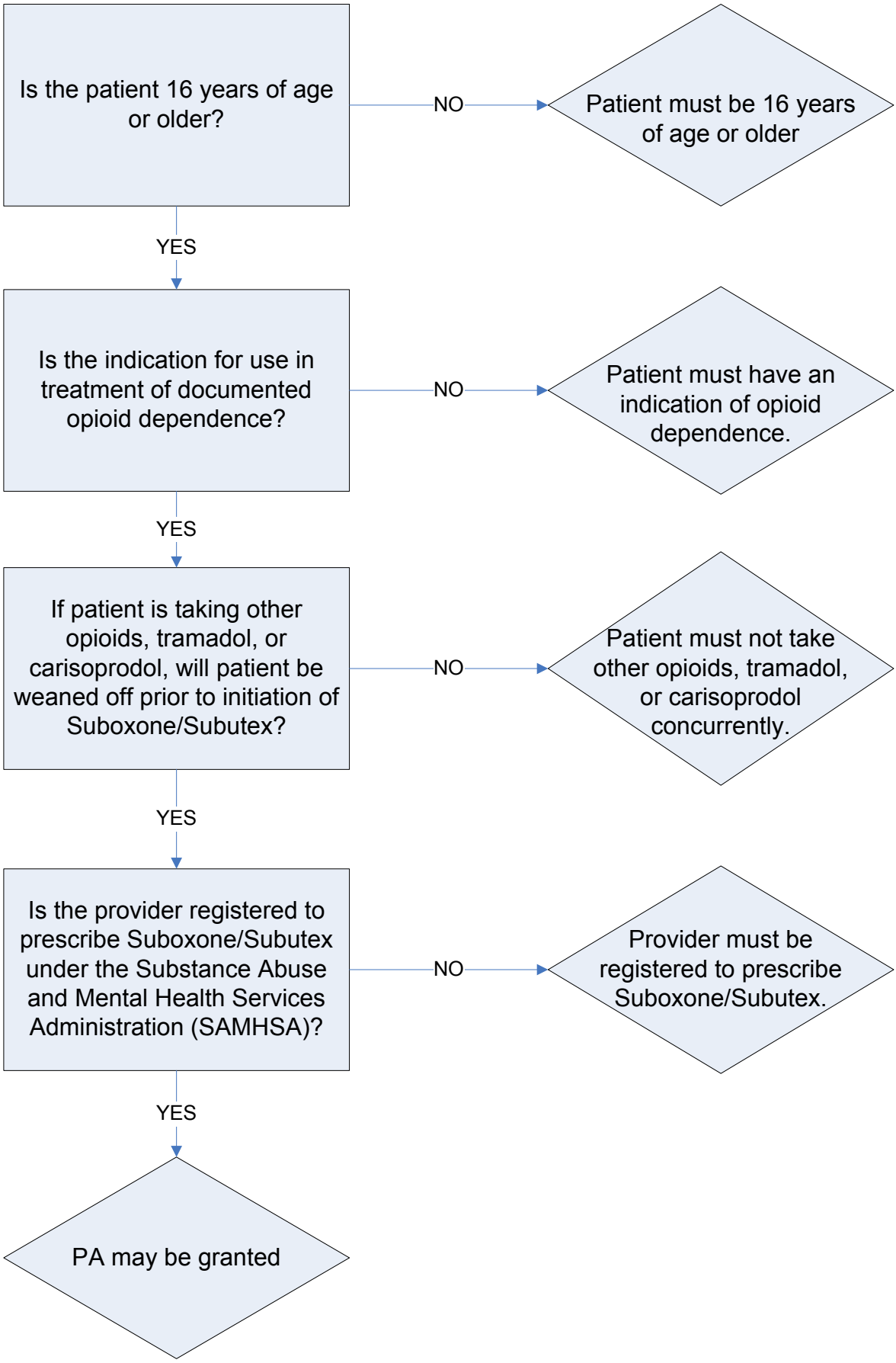
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Suboxone/Subutex Authorization Algorithm



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: ☐ EMLA ☐ SYNERA	**Medical Procedure:**		
Physician Signature		Date	

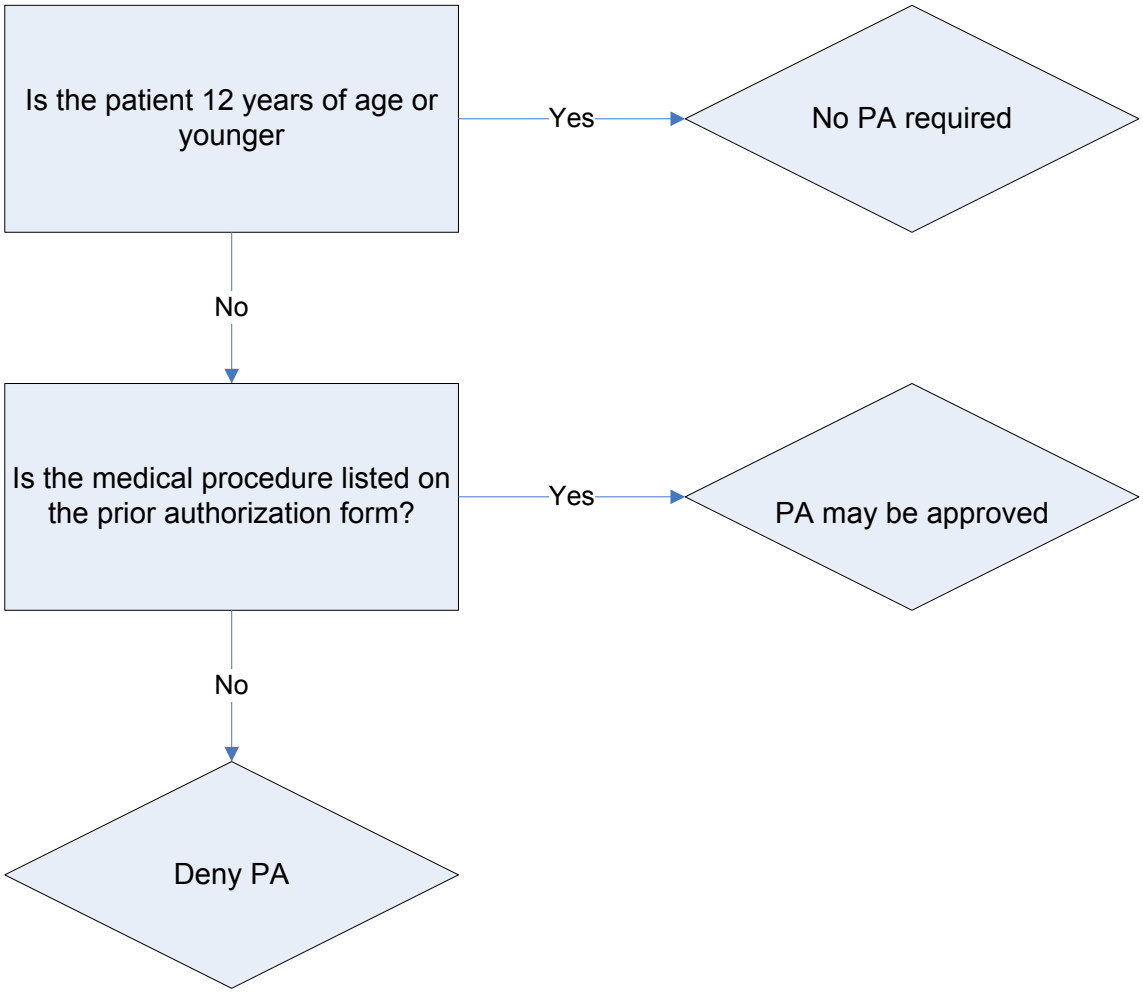
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Local Anesthetics (Topical) Prior Authorization Algorithm



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: □ **Extina** □ **Xolegel** □ **Ketocon Plus**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Medication Failed _____	Start Date: End Date:	Dose: Frequency:	
Physician Signature		Date	

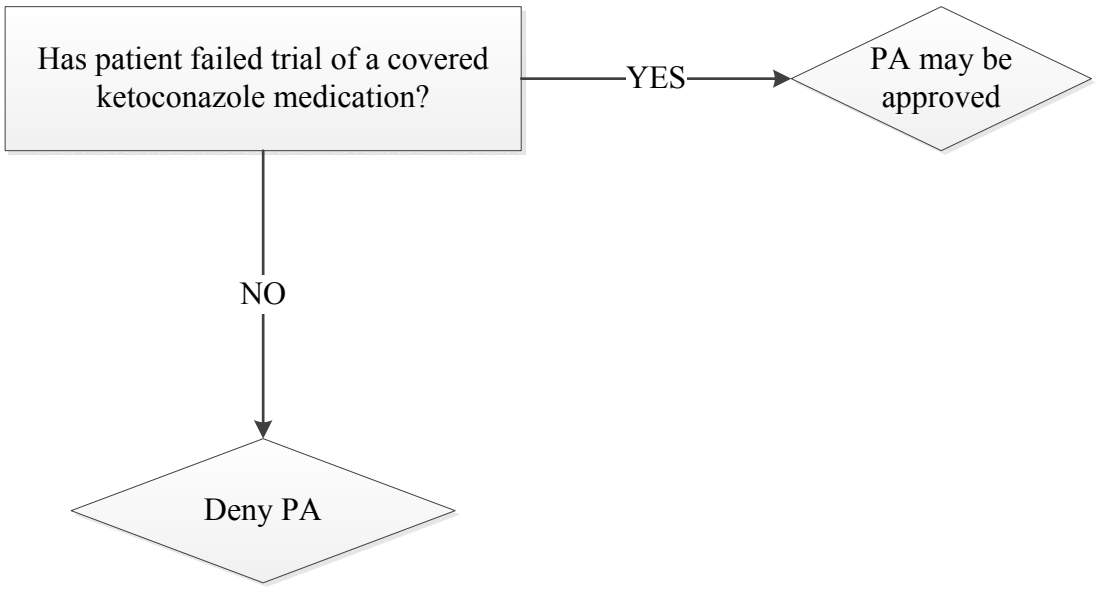
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Topical Ketoconazole Products Authorization Algorithm



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: □ ULTRAM ER OR GENERIC □ RYZOLT □ RYBIX	**Diagnosis for this request:**

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

Physician Signature	Date

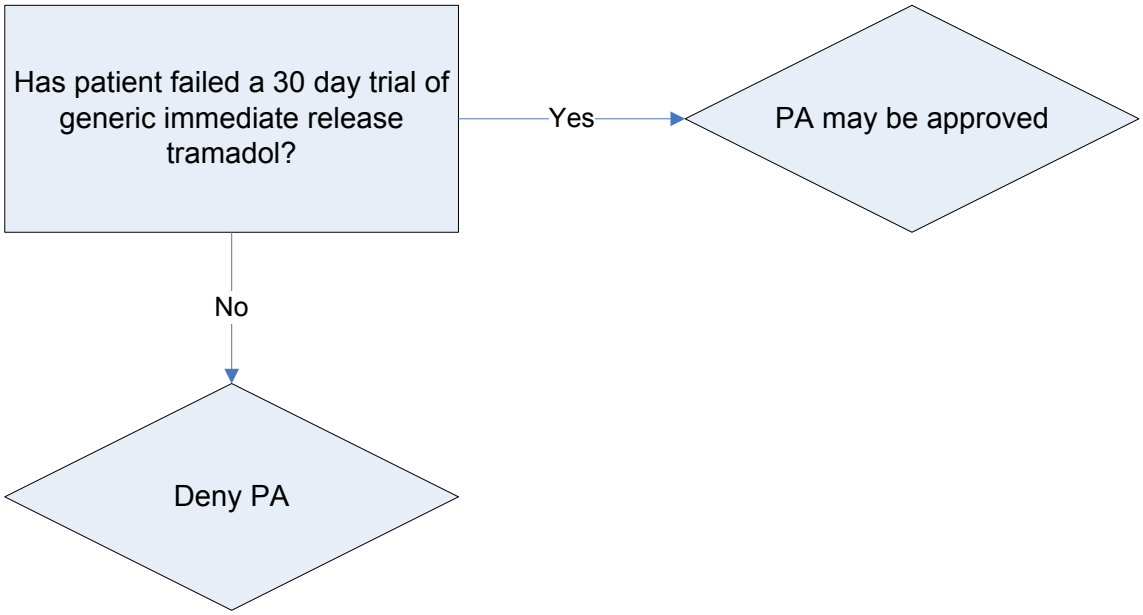
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Tramadol ER Prior Authorization Algorithm



Serotonin (5-HT$_1$) Receptor Agonists - Triptan 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 Axert, Frova, Maxalt, Relpax, Treximet, or Zomig must try sumatriptan then naratriptan as first line therapies.

*__Note:__

- **Sumatriptan and naratriptan do 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:	**Diagnosis for this request:**
□ RELPAX □ MAXALT □ AXERT □ TREXIMET □ FROVA □ ZOMIG	

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

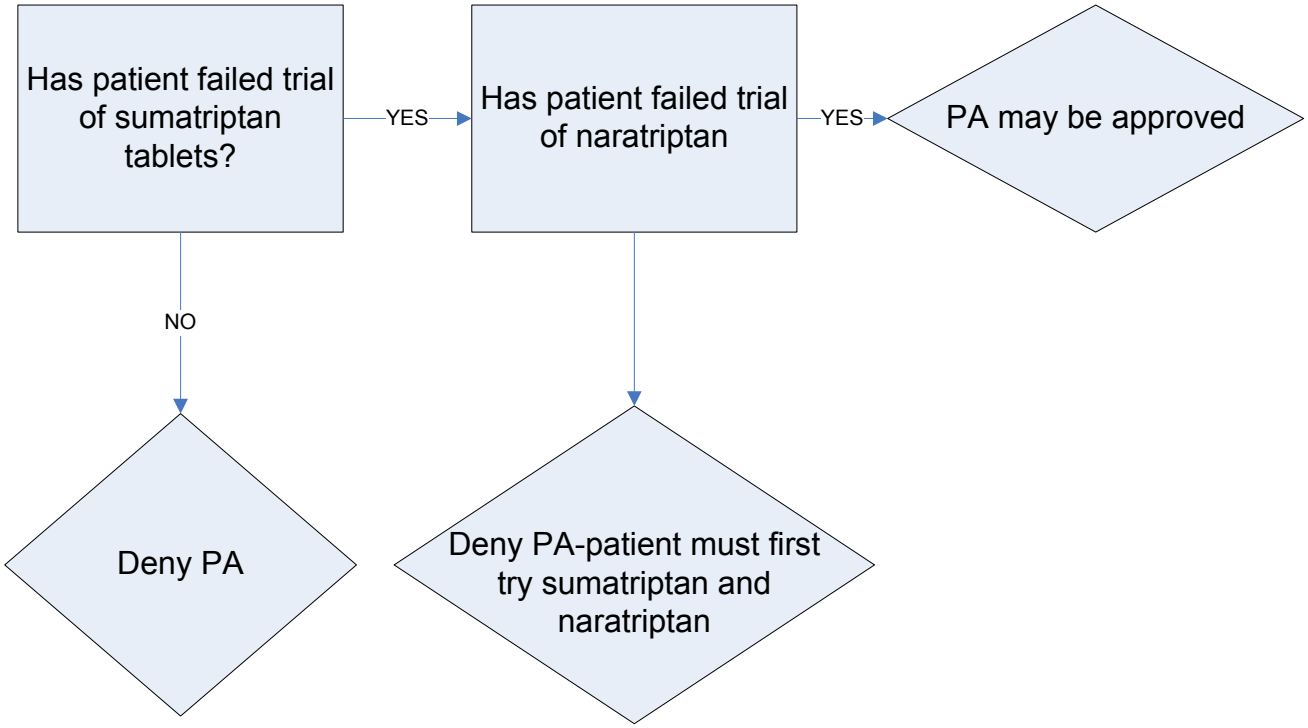
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Serotonin (5-HT_1) Receptor Agonists
Triptan Prior Authorization Algorithm



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: □ 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	

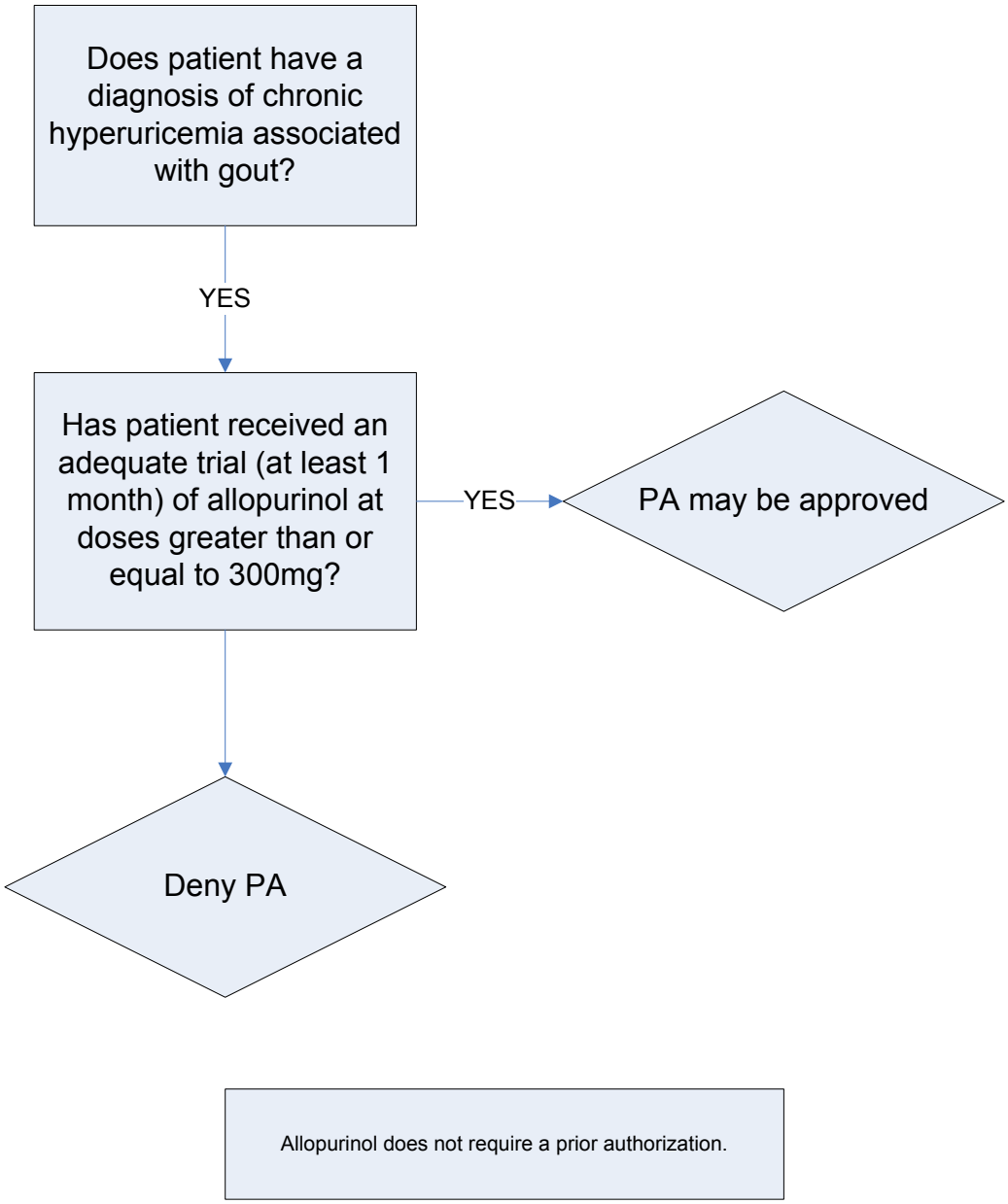
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Uloric Authorization Algorithm



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: □ VUSION	**Diagnosis for this request:**		

Qualifications for coverage:

□ Failed antifungal therapy Name of medication failed: _____	Start Date	End Date	Dose	Frequency

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber Signature	Date

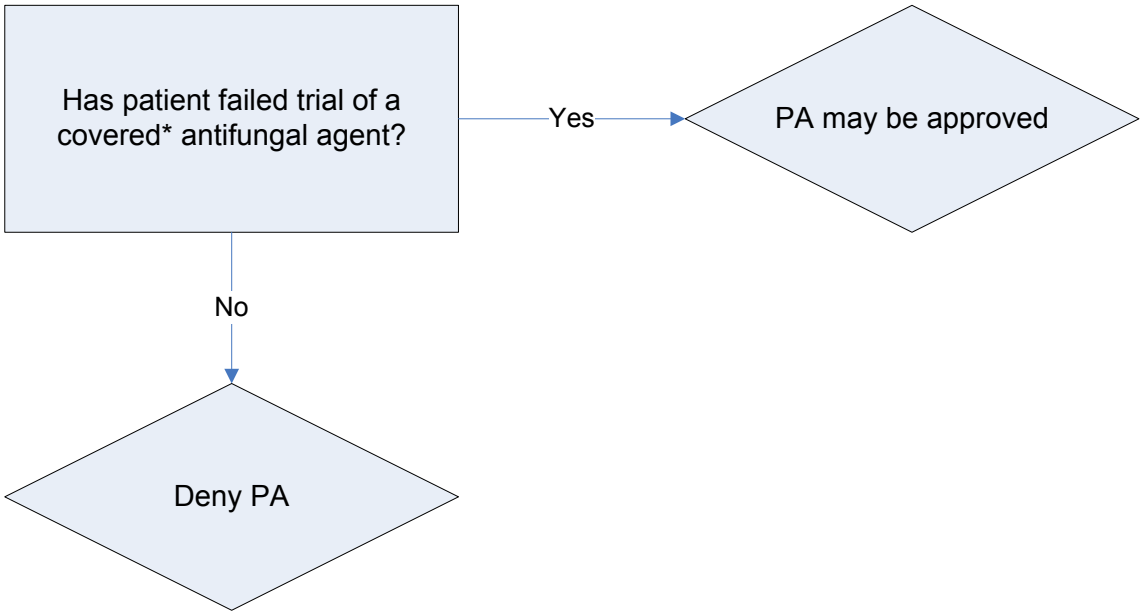
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Vusion Prior Authorization Algorithm



*Nystatin and clotrimazole do not require a PA and cost approximately $6 - $36 for a course of therapy compared to $246 for a course of Vusion therapy.

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: □ XENICAL	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Dietician evaluation attached	Height:	Weight:	BMI:
Prescriber Signature		Date	

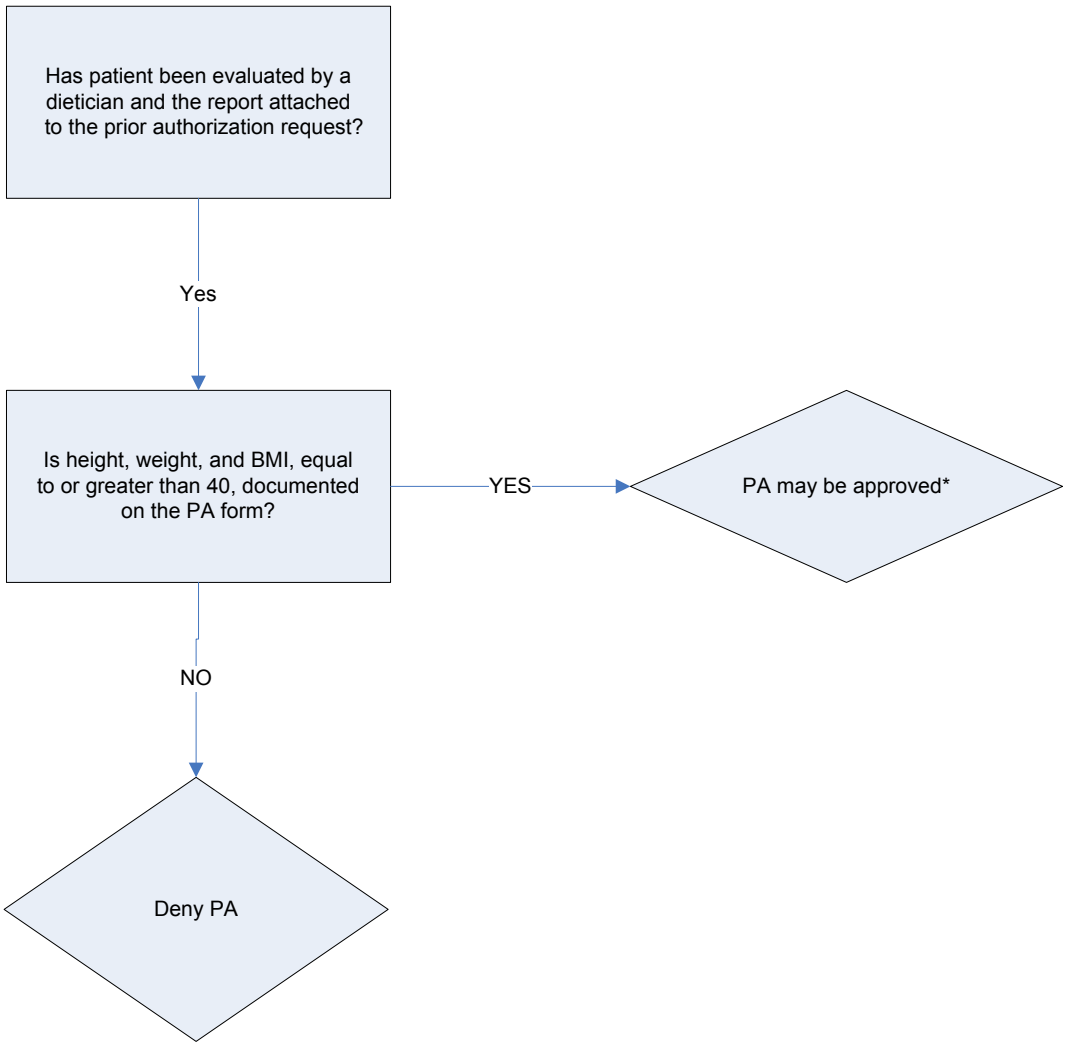
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Xenical Prior Authorization Criteria



*5% weight loss must be realized for continued approval every 6 months.

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: □ XOLAIR	**Diagnosis for this Request:**	**Serum IgE Level:**
Physician Signature		Date

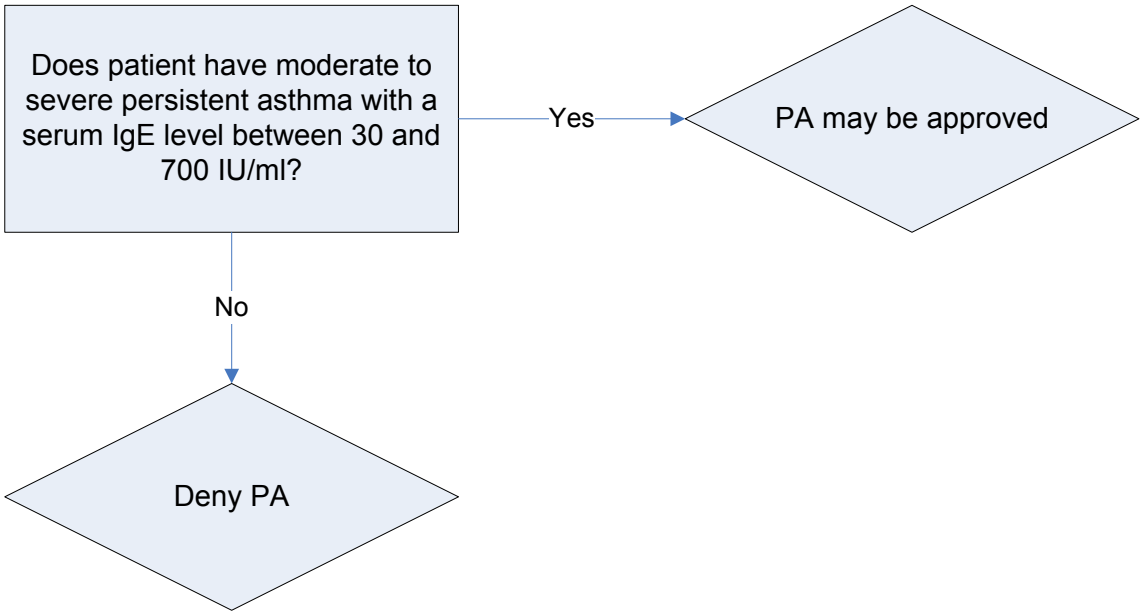
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Xolair Prior Authorization Algorithm



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: □ **Xyrem**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Enrolled in Xyrem Success Program	Enrolled Date:	Dose:	
Physician Signature		Date	

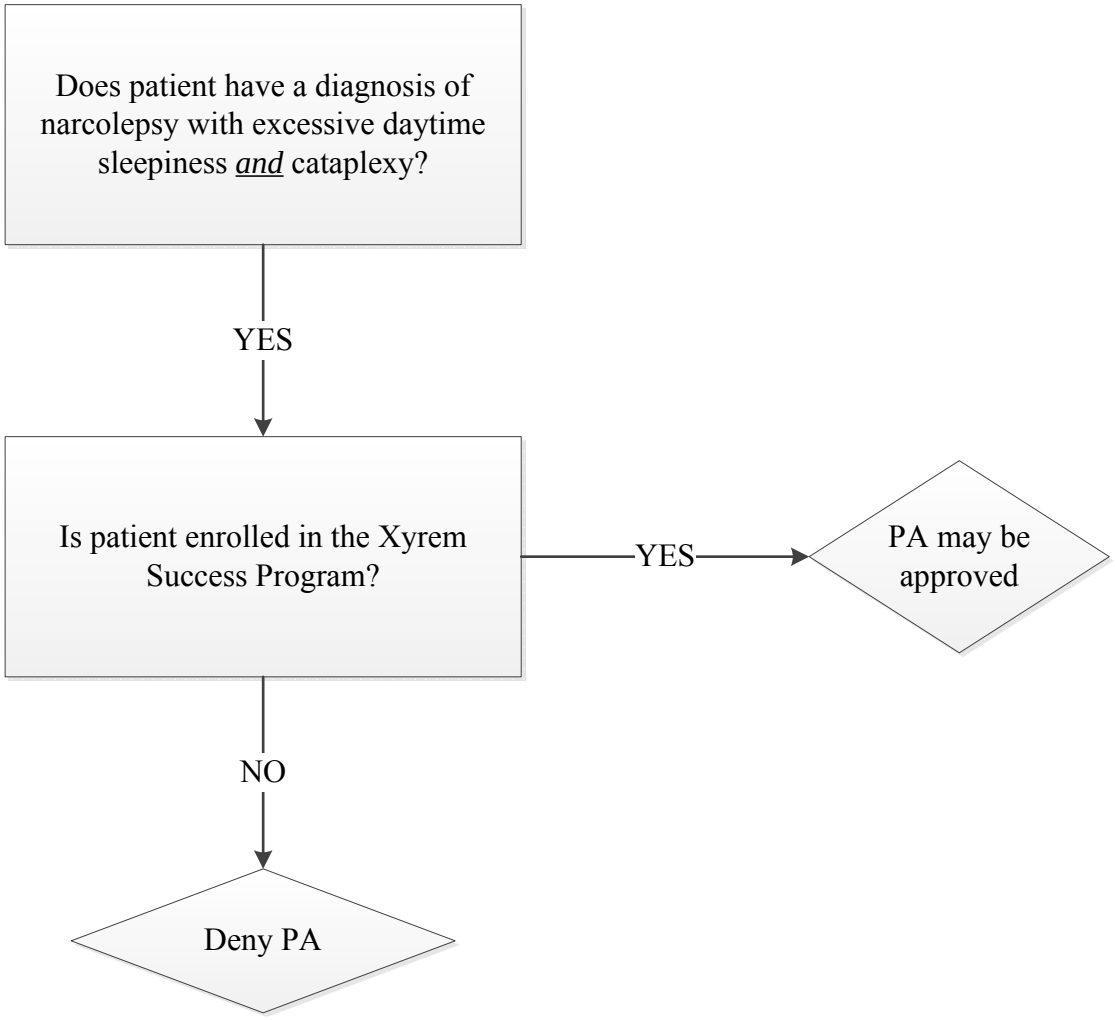
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Xyrem Authorization Algorithm



HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Zanaflex Capsule PA Form

Fax Completed Form to:
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: 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	

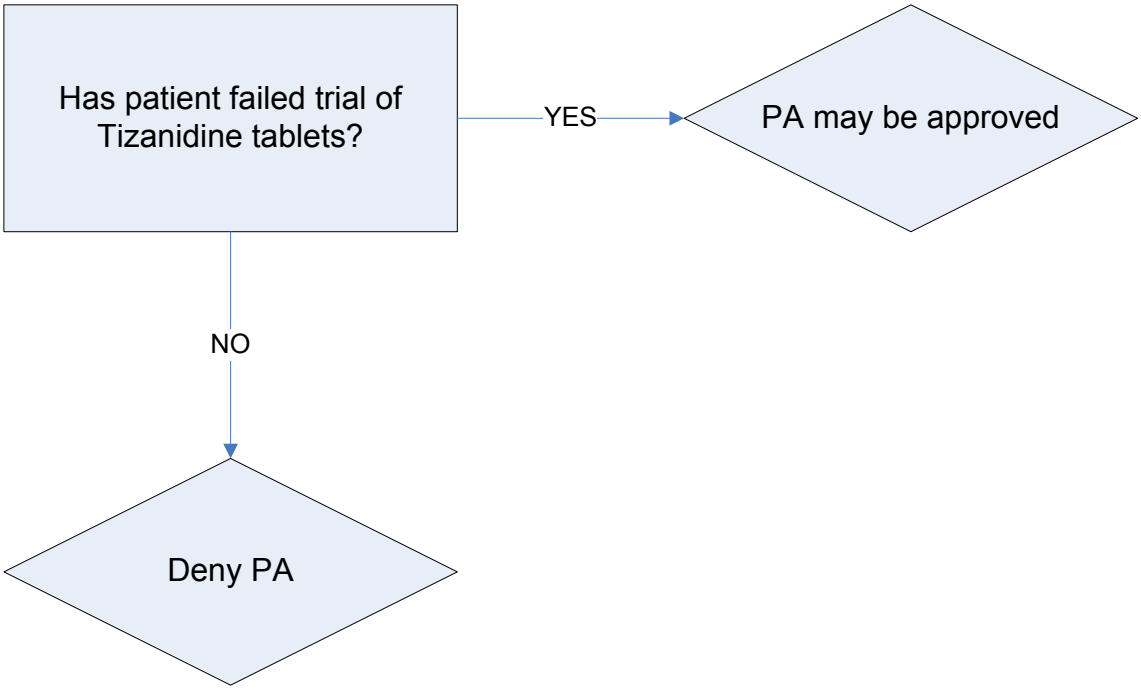
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Zanaflex Authorization Algorithm



Zyclara 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 Zyclara first try imiquimod.
Note:

- ***Imiquimod 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: □ **Zyclara**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ **Trial of imiquimod** **Start Date** **End Data**			
Physician Signature	Date		

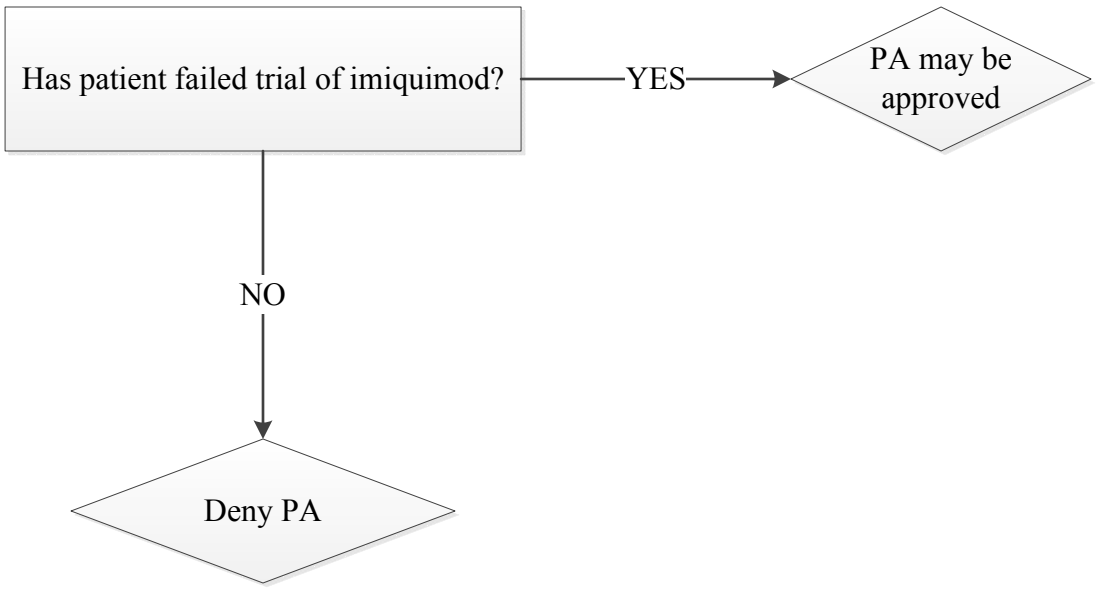
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Zyclara Authorization Algorithm



Smoking Cessation Program

North Dakota Quitline

1-800-QUIT-NOW

Prior Authorization Vendor for ND Medicaid

North Dakota Medicaid has recently joined forces with the Department of Health to provide free, confidential, telephone-based cessation counseling 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 the North Dakota Tobacco Quitline (1-800-QUIT-NOW or 1-800-784-8669). Once a recipient is enrolled in counseling, they will work with their counselor to determine which medications they wish to use. The complete process is described below:

1. Patient calls ND Quitline and enrolls in counseling.
2. Quitline counselors 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 Quitline'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.

North Dakota Department of Human Services
DUR Board Meeting
Genitourinary Smooth Muscle Relaxants

I. Overview

Normal voiding is dependent on acetylcholine-induced stimulation of muscarinic receptors on bladder smooth muscle. Darifenacin, fesoterodine, solifenacin, tolterodine and trospium act as muscarinic receptor antagonists, inhibiting bladder contraction, decreasing detrusor pressure (decreasing urgency) and increasing bladder capacity. Flavoxate has direct antispasmodic effects on the smooth muscle of the bladder, thereby reducing symptoms associated with bladder spasticity and increasing bladder capacity. Oxybutynin also has a direct antispasmodic effect on smooth muscle, but also inhibits the muscarinic action of acetylcholine. Mirabegron is a beta-3 adrenergic agonist that relaxes the detrusor smooth muscle.

Muscarinic receptors can also be found in the gastrointestinal tract, salivary glands and tear ducts. Because these agents have varying affinity for the different types of muscarinic receptors, common side effects include dry mouth, blurred vision, abdominal discomfort, drowsiness and nausea. In addition, these agents may cause confusion or cognitive impairment in the elderly.

Genitourinary Smooth Muscle Relaxants Included In This Review

Generic Name	Available Formulation(s)	Brand Name(s)
Darifenacin	Extended-release tablet	Enablex®
Fesoterodine	Extended-release tablet	Toviaz®
Flavoxate	Tablet	N/A
Oxybutynin	Tablet, syrup, extended-release tablet, transdermal gel, transdermal patch	Ditropan®*, Ditropan XL®*, Gelnique®, Oxytrol®
Solifenacin	Tablet	Vesicare®
Tolterodine	Tablet, extended-release tablet	Detrol®*, Detrol LA®
Trospium	Tablet, extended-release tablet	Sanctura®*, Sanctura XR®
Mirabegron	Extended-release tablet	Myrbetriq®

*Indicates that a generic product is available.

II. Indications

Darifenacin, fesoterodine, solifenacin, tolterodine, trospium and mirabegron are indicated for the treatment of overactive bladder (OAB) with symptoms of urinary incontinence, urgency and frequency. Flavoxate is indicated for symptomatic relief of dysuria, urgency, nocturia, suprapubic pain, frequency and incontinence that may occur in cystitis, prostatitis, urethritis, urethrocystitis/urethrotrigonitis. Oxybutynin immediate-release tablets and syrup are indicated for the relief of symptoms of bladder instability associated with voiding in patients with uninhibited neurogenic or reflex neurogenic bladder. Oxybutynin extended-release tablets, transdermal patch and transdermal gel are indicated for the treatment of OAB. Oxybutynin is also indicated in patients ages 6 years and older with symptoms of detrusor overactivity associated with a neurological condition (e.g., spina bifida).

III. Warnings

- These agents should be used with caution in patients with clinically significant bladder outflow obstruction because of the risk of urinary retention.

- Agents for the treatment of OAB should also be used with caution in patients with gastrointestinal obstructive disorders (e.g., ulcerative colitis, severe constipation) because of the risk of gastric retention and decreased gastric motility.

- GU smooth muscle relaxants should be used with caution in patients with controlled narrow-angle glaucoma and myasthenia gravis, due to effects of increased anticholinergic activity.

- Oxybutynin transdermal gel is alcohol-based and therefore flammable. Instruct patients to avoid open fire or smoking until gel has dried.

- Mirabegron can increase blood pressure. Periodic blood pressure determinations are recommended, especially in hypertensive patients. Mirabegron is not recommended for use in severe uncontrolled hypertensive patients.

- Mirabegron is a moderate inhibitor of CYP2D6. Appropriate monitoring is recommended and dose adjustment may be necessary for narrow therapeutic index CYP2D6 substrates.

IV. Precautions

Recommendations For Dosage Adjustments Based On Hepatic and Renal Function

Generic Name	Renal Function Impairment	Hepatic Function Impairment
Darifenacin	*No dosage adjustments	*No dosage adjustments for mild hepatic impairment *Max dose = 7.5mg for patients with moderate hepatic impairment (Child-Pugh class B) *Not recommended for patients with severe hepatic impairment (Child-Pugh class C)
Fesoterodine	*No dosage adjustments for patients with mild/moderate renal insufficiency. *Max dose = 4mg for patients with severe renal insufficiency	*No dosage adjustments for patients with mild/moderate hepatic impairment. *Not recommended for patients with severe hepatic impairment
Flavoxate	*No recommendations	*No recommendations
Oxybutynin	*Use with caution - no recommendations for dosage adjustments	*Use with caution - no recommendations for dosage adjustments

Generic Name	Renal Function Impairment	Hepatic Function Impairment
Solifenacin	*Use with caution in patients with reduced renal function *Max dose = 5mg in patients with severe renal impairment (CrCl < 30mL/min)	*Use with caution in patients with reduced hepatic function *Max dose = 5mg in patients with moderate hepatic impairment (Child-Pugh class B) *Not recommended for patients with severe hepatic impairment (Child-Pugh class C)
Tolterodine	*IR – Significantly reduced renal function, recommended dose is 1mg BID *ER – Severe renal impairment (CrCl 10 to 30mL/min), recommended dose is 2mg QD. If CrCl is less than 10mL/min, use is not recommended	*IR – Significantly reduced hepatic function, recommended dose is 1mg BID *ER – Mild to moderate hepatic impairment (Child-Pugh class A or B), recommended dose is 2mg QD. If patient has severe hepatic impairment (Child-Pugh class C), use is not recommended
Trospium	*IR – Severe renal impairment (CrCl < 30mL/min), recommended dose is 20mg HS. *ER – Not recommended for use in patients with severe renal impairment (CrCl < 30mL/min)	*Use caution when administering to patients with moderate or severe hepatic dysfunction.
Mirabegron	In patients with severe renal impairment, the daily dose should not exceed 25mg. No dose adjustment is necessary in patients with mild or moderate renal impairment.	In patients with moderate hepatic impairment, the daily dose should not exceed 25mg. No dose adjustment is necessary in patients with mild hepatic impairment.

V. Drug Interactions

- When genitourinary smooth muscle relaxants (darifenacin, fesoterodine, solifenacin, tolterodine) are used concurrently with agents that inhibit CYP3A4 (imidazoles, macrolides, nefazodone and protease inhibitors), the plasma concentrations and effects of the genitourinary smooth muscle relaxant may be increased.

- When genitourinary smooth muscle relaxants (oxybutynin, trospium) are used with phenothiazines, the antipsychotic effectiveness of the phenothiazines may be decreased.

- Potassium tablet preparations are contraindicated for use in patients using anticholinergic agents like the genitourinary smooth muscle relaxants. Delay in tablet passage through the GI tract may occur, affecting potassium absorption. Administration of the potassium as a liquid preparation is a suitable alternative.

- Mirabegron is a moderate inhibitor of CYP2D6 and when used concomitantly with drugs metabolized by CYP2D6, especially narrow therapeutic index drugs, appropriate monitoring and possible dosage adjustment of those drugs may be necessary.

- When initiating a combination of mirabegron and digoxin, prescribe the lowest dose of digoxin; monitor serum digoxin concentrations to titrate digoxin dose to desired clinical effect.

VI. Adverse Reactions

- The most common adverse reactions to the genitourinary smooth muscle relaxants are urinary retention, dry mouth and constipation.

- Other side effects include dry eyes, dizziness/somnolence, abdominal pain, nausea, dyspepsia, urinary tract infection, nasopharyngitis, headache and hypertension.

- Hypersensitivity reactions, including angioedema with airway obstruction, pruritis, rash and urticaria have occurred.

VII. Dosage and Administration

Adult and Pediatric Dose Recommendations

Generic Name	Adult Dose Recommendations	Pediatric Dose Recommendations	Availability
Darifenacin	7.5 to 15mg daily	Safety and efficacy in children have not been established.	ER Tablet: 7.5mg 15mg
Fesoterodine	4 to 8mg daily	Safety and efficacy in children have not been established.	ER Tablet: 4mg 8mg
Flavoxate	100 to 200mg 3 to 4 times/day	≥12 years of age: 100 to 200mg 3 to 4 times/day	Tablet: 100mg
Oxybutynin	Tablet (IR)/syrup: 5mg 2 to 3 times/day; max dose = 5mg 4 times/day Tablet (ER): 5mg daily; max dose = 30 mg/day Transdermal gel: 10% - one sachet applied daily 3% - apply 3 pumps daily Transdermal patch: one 3.9mg/day system applied twice weekly (every 3 to 4	≥5 years of age: Tablet (IR)/syrup: 5mg 2 times a day; max dose = 5mg 3 times a day ≥6 years of age (detrusor overactivity associated with a neurological condition): Tablet (ER): 5mg once daily; max dose = 20mg/day	Syrup: 5mg/5mL ER Tablet: 5mg 10mg 15mg IR Tablet: 5mg Transdermal gel: 3%, 10%

Generic Name	Adult Dose Recommendations	Pediatric Dose Recommendations	Availability
	days)		Transdermal patch: 3.9mg/24hr
Solifenacin	5 to 10mg daily	Safety and efficacy in children have not been established.	Tablet: 5mg 10mg
Tolterodine	Tablet (IR): 2mg 2 times/day Capsule (ER): 4mg once daily	Safety and efficacy in children have not been established.	IR Tablet: 1mg 2mg ER Capsule: 2mg 4mg
Trospium	Tablet (IR): 20mg 2 times/day Capsule (ER): 60mg daily	Safety and efficacy in children have not been established.	IR Tablet: 20mg ER Capsule: 60mg
Mirabegron	Tablet (ER): 25mg once daily, may increase to 50mg once daily if effective within 8 weeks.	Safety and efficacy in children have not been established.	ER Tablet: 25mg 50mg

VIII. Utilization

Genitourinary Smooth Muscle Relaxant Utilization			
09/26/11 - 09/25/12			
Label Name	**Rx Num**	**Total Reimb Amt**	**Average Cost per Script**
DETROL 2 MG TABLET	42	$6,884.03	$163.91
DETROL LA 2 MG CAPSULE	57	$8,136.68	$142.75
DETROL LA 4 MG CAPSULE	415	$64,650.72	$155.78
DITROPAN XL 10 MG TABLET	1	$90.40	$90.40
ENABLEX 15 MG TABLET	26	$4,030.36	$155.01
ENABLEX 7.5 MG TABLET	44	$5,307.17	$120.62
FLAVOXATE HCL 100 MG TABLET	4	$443.80	$110.95
OXYBUTYNIN 5 MG TABLET	444	$4,201.52	$9.46
OXYBUTYNIN 5 MG/5 ML SYRUP	113	$1,711.90	$15.15
OXYBUTYNIN CL ER 10 MG TABLET	362	$17,795.20	$49.16
OXYBUTYNIN CL ER 15 MG TABLET	175	$9,781.99	$55.90
OXYBUTYNIN CL ER 5 MG TABLET	88	$3,377.42	$38.38
OXYTROL 3.9 MG/24HR PATCH	21	$4,125.66	$196.46
SANCTURA XR 60 MG CAPSULE	56	$7,721.79	$137.89
TOLTERODINE TARTRATE 2 MG TAB	3	$545.01	$181.67

Genitourinary Smooth Muscle Relaxant Utilization			
09/26/11 - 09/25/12			
Label Name	**Rx Num**	**Total Reimb Amt**	**Average Cost per Script**
TOVIAZ ER 4 MG TABLET	38	$5,284.72	$139.07
TOVIAZ ER 8 MG TABLET	53	$7,089.21	$133.76
TROSPIUM CHLORIDE 20 MG TABLET	6	$495.34	$82.56
VESICARE 10 MG TABLET	129	$21,488.98	$166.58
VESICARE 5 MG TABLET	86	$14,919.16	$173.48
Totals (361 Recipients)	**2163**	**$188,081.06**	
Myrbetriq will cost about $210 per month			

References

1. Facts and Comparisons, Wolters Kluwer Health, Inc. 2012.
2. Clinical Pharmacology, 2012 Elsevier/Gold Standard.
3. Micromedex 2.0 DRUGDEX Drug Evaluations, 2012 Thomson Healthcare.
4. Enablex [package insert]. Rockaway, NJ: Warner Chilcott (US) LCC; March 2012.
5. Toviaz [package insert]. New York, NY: Pfizer; August 2012.
6. Ditropan XL [package insert]. Raritan, NJ: Ortho-McNeil-Janssen; March 2012.
7. Gelnique Gel 10% [package insert]. Parsippany, NJ: Watson Pharma, Inc.; March 2012.
8. Gelnique Gel 3% [package insert]. Parsippany, NJ: Watson Pharma, Inc.; December 2011.
9. Oxytrol [package insert]. Parsippany, NJ: Watson Pharma, Inc.; April 2011.
10. Vesicare [package insert]. Northbrook, IL: Astellas Pharma US, Inc.; August 2012.
11. Detrol LA [package insert]. New York, NY: Pfizer; August 2012.
12. Sanctura [package insert]. Irvine, CA: Allergan, Inc.; July 2012.
13. Sanctura XR [package insert]. Irvine, CA: Allergan, Inc.; August 2012.
14. Myrbetriq [package insert]. Northbrook, IL: Astellas Pharma US, Inc.; June 2012.

North Dakota Department of Human Services
DUR Board Meeting
Aubagio® Review

I. Overview

Teriflunomide, an immunomodulatory agent with anti-inflammatory properties, inhibits dihydroorotate dehydrogenase, a mitochondrial enzyme involved in de novo pyrimidine synthesis. The exact mechanism by which teriflunomide exerts its therapeutic effect in multiple sclerosis is unknown but may involve a reduction in the number of activated lymphocytes in the central nervous system. Teriflunomide is the active metabolite of leflunomide (Arava), the immunomodulatory used to slow progression of rheumatoid arthritis.

II. Indication

Teriflunomide is a pyrmidine synthesis inhibitor indicated for the treatment of patients with relapsing forms of multiple sclerosis.

III. Warnings and Precautions

- Elimination of teriflunomide can be accelerated by administration of cholestyramine or activated charcoal for 11 days.
- Teriflunomide may decrease WBC. A recent CBC should be available before starting teriflunomide. Monitor for signs and symptoms of infection. Consider suspending treatment with teriflunomide and using accelerated elimination procedure in case of serious infection. Do not start teriflunomide in patients with active infections.
- Peripheral neuropathy: If patient develops symptoms consistent with peripheral neuropathy, evaluate patient and consider discontinuing teriflunomide and using accelerated elimination procedure.
- Acute renal failure/hyperkalemia: Monitor renal function and potassium in patients with symptoms of renal failure or hyperkalemia.
- Severe skin reaction: Stop teriflunomide and use accelerated elimination procedure.
- Blood pressure: Measure at treatment initiation. Monitor and manage appropriately during treatment.

IV. Drug Interactions

- Drugs metabolized by CYP2C8: monitor patients as teriflunomide may increase their exposure.
- Teriflunomide may increase exposure of ethinyl estradiol and levonorgestrel. Choose an appropriate oral contraceptive.
- Drugs metabolized by CYP1A2: Monitor patients as teriflunomide may decrease their exposure.
- Warfarin: monitor INR as teriflunomide may decrease INR.

V. Adverse Reactions

The most common adverse reactions (≥10% and ≥2% greater than placebo): ALT increased, alopecia, diarrhea, influenza, nausea, and paresthesias.

VI. Dosage and Administration

The recommended dose of teriflunomide is 7 mg or 14 mg orally once daily.

- Obtain transaminase and bilirubin levels within 6 months before initiation of teriflunomide therapy. Monitor ALT levels at least monthly for six months after starting teriflunomide.
- Obtain a complete blood cell count (CBC) within 6 months before the initiation of treatment with teriflunomide. Further monitoring should be based on signs and symptoms of infection.
- Prior to initiating teriflunomide, screen patients for latent tuberculosis infection with a tuberculin skin test.
- Check blood pressure before start of teriflunomide and periodically thereafter.

VII. Cost

Aubagio costs approximately $4,500/month.

Reference

1. Aubagio® [prescribing information]. Cambridge, MA. Genzyme Corporation.; Sep 2012.

NORTH DAKOTA MEDICAID
RETROSPECTIVE DRUG UTILIZATION REVIEW
CRITERIA RECOMMENDATIONS
DECEMBER 2012

Criteria Recommendations	*Approved*	*Rejected*

1. Mirabegron / High Dose _____ _____

Alert Message: The manufacturer's maximum recommended daily dose of Myrbetriq (mirabegron) is 50 mg once daily.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Mirabegron		Severe Renal Impairment
		Hepatic Impairment

Max dose: 50mg/day

References:
Myrbetriq Prescribing Information, June 2012, Astellas Pharma US, Inc.

2. Mirabegron / Severe Renal Impairment or Mod. Hepatic Impairment _____ _____

Alert Message: The daily dose of Myrbetriq (mirabegron) should not exceed 25 mg in patients with severe renal impairment (CrCL 15-29mL/min) or moderate hepatic impairment (Child-Pugh Class B). Mirabegron use is not recommended in patients with end-stage renal disease (ESRD) or patients with severe hepatic impairment.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Mirabegron		Severe Renal Impairment
		Hepatic Impairment

Max Dose: 25 mg/day
References:
Myrbetriq Prescribing Information, June 2012, Astellas Pharma US, Inc.

3. Mirabegron / Hypertension & Antihypertensive Medications _____ _____

Alert Message: Myrbetriq (mirabegron) can increase blood pressure and periodic blood pressure determinations are recommended especially in hypertensive patients. Mirabegron is not recommended for use in severe uncontrolled hypertensive patients.

Conflict Code: DB – Drug Disease and/or Drug Inferred Disease Precaution
Drugs/Diseases

Util A	Util B	Util C
Mirabegron	Hypertension ICD-9s	
	Antihypertensive Meds	

References:
Myrbetriq Prescribing Information, June 2012, Astellas Pharma US, Inc.

4. Mirabegron / Bladder Outlet Obstruction _____ _____

Alert Message: Myrbetriq (mirabegron) should be administered with caution to patients with clinically significant bladder outlet obstruction (BOO). Urinary retention in patients with BOO has been reported in postmarketing experience in patients taking mirabegron.

Conflict Code: MC – Drug/Disease Precaution
Drugs/Diseases

Util A	Util B	Util C
Mirabegron	Bladder Obstruction	

References:
Myrbetriq Prescribing Information, June 2012, Astellas Pharma US, Inc.

5. Mirabegron / Antimuscarinic Medications _____ _____

Alert Message: Myrbetriq (mirabegron) should be administered with caution to patients taking antimuscarinic medications for the treatment of overactive bladder (OAB). Urinary retention in patients taking antimuscarinic medications for the treatment of OAB has been reported in postmarketing experience in patients taking mirabegron.

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

Util A	Util B	Util C
Mirabegron	Darifenacin	
	Fesoterodine	
	Oxybutynin	
	Solifenacin	
	Tolterodine	
	Trospium	

References:
Myrbetriq Prescribing Information, June 2012, Astellas Pharma US, Inc.

6. Mirabegron / Digoxin _____ _____

Alert Message: For patients who are initiating a combination of Myrbetriq (mirabegron) and digoxin, the lowest dose for digoxin should initially be considered. The concurrent use of mirabegron and digoxin has been shown to increase the Cmax and AUC of digoxin, 29% and 27%, respectively. Serum digoxin concentrations should be monitored and used for titration of the digoxin dose to obtain the desired clinical effect.

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

Util A	Util B	Util C
Mirabegron	Digoxin	

References:
Myrbetriq Prescribing Information, June 2012, Astellas Pharma US, Inc.

7. Mirabegron / Pediatric Patients _____ _____

Alert Message: The safety and effectiveness of Myrbetriq (mirabegron) in pediatric patients have not been established.

Conflict Code: TA – Therapeutic Effectiveness
Drugs/Diseases

Util A	Util B	Util C
Mirabegron		

Age Range: 0-18 yoa

References:
Myrbetriq Prescribing Information, June 2012, Astellas Pharma US, Inc.

8. Mirabegron / Drugs Metabolized by CYP2D6 _____ _____

Alert Message: Myrbetriq (mirabegron) is a moderate CYP2D6 inhibitor and co-administration with a drug that is a CYP2D6 substrate may result in increased systemic exposure to the substrate. Appropriate monitoring and dose adjustment may be necessary, especially with narrow therapeutic index drugs metabolized by CYP2D6.

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

Util A	Util B				Util C
Mirabegron	Thioridazine*	Codeine	Morphine	Imipramine	
	Flecainide*	Cyclobenzaprine	Nortriptyline	Venlafaxine	
	Propafenone*	Darifenacin	Olanzapine	Metoclopramide	
	Atomoxetine*	Delavirdine	Ondansetron		
	Desipramine*	Dextromethorphan	Oxycodone		
	Dextroamphetamine*	Dolasetron	Paroxetine		
	Metoprolol*	Donepezil	Penbutolol		
	Nebivolol*	Doxepin	Pentazocine		
	Perphenazine*	Fluvoxamine	Propranolol		
	Almotriptan	Fluoxetine	Perphenazine		
	Amphetamine	Fluphenazine	Pimozide		
	Arformoterol	Haloperidol	Protriptyline		
	Aripiprazole	Hydrocodone	Risperidone		
	Asenapine	Iloperidone	Sertraline		
	Atomoxetine	Labetalol	Tamoxifen		
	Carvedilol	Maprotiline	Timolol		
	Chlorpheniramine	Methamphetamine	Tolterodine		
	Clomipramine	Metoprolol	Tramadol		
	Citalopram	Mexiletine	Trimipramine		
	Clozapine	Mirtazapine	Amitriptyline		

References:
Myrbetriq Prescribing Information, June 2012, Astellas Pharma US, Inc.
Hartshorn EA, Tatro DS. Principles of Drug Interactions Facts & Comparisons, 2012 Wolters Kluwer Health, Inc.
FDA: Drug Development and Drug Interactions: Tables of Substrates, Inhibitors and Inducers. [08/28/2012]. Available at:
http://www.fda.gov/Drugs/DevelopmentApprovalProcess/DevelopmentResources/DrugInteractionsLabeling/ucm093664.htm
*CYP2D6 Sensitive substrate and/or narrow therapeutic index CYP2D6 substrate

9. Stribild / Other Antiretroviral Therapy _____ _____

Alert Message: The patient appears to be receiving other antiretroviral therapy in addition to Stribild (elvitegravir/cobicistat/emtricitabine/tenofovir). Stribild is a complete regimen for the treatment of HIV-1 infections and should not be administered with other antiretroviral medications.

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

Util A	Util B	Util C
Stribild	All Other Antiretrovirals	

References:
Stribild Prescribing Information, August 2012, Gilead Sciences, Inc.

10. Fosamprenavir / Delavirdine _____ _____

Alert Message: The concurrent use of Lexiva (fosamprenavir) and delavirdine is contraindicated. Co-administration of these agents may lead to loss of virologic response and possible resistance to delavirdine.

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

Util A	Util B	Util C
Fosamprenavir	Delavirdine	

References:
Facts & Comparisons, 2012 Updates.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.

11. Revatio / Children 1-17 years of Age _____ _____

Alert Message: Revatio (sildenafil) should not be prescribed to children (ages 1 through 17) for pulmonary arterial hypertension (PAH). This recommendation is based on a recent long-term clinical pediatric trial showing that: (1) children taking a high dose of Revatio had a higher risk of death than children taking a low dose and (2) the low doses of Revatio are not effective in improving exercise ability. Revatio is not FDA approved for the treatment of PAH in children.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Revatio		

Age Range: 1-17 yoa

References:
MedWatch The FDA Safety Information and Adverse Event Reporting Program Safety Information. Revatio (sildenafil): Drug Safety Communication - Recommendation Against Use in Children [Posted 08/30/2012].

12. Didanosine / Ribavirin _____ _____

Alert Message: The concurrent use of didanosine (Videx/Videx EC) with a ribavirin-containing agent is contraindicated. Co-administration of these agents may cause significant increases in blood concentrations of didanosine and its active metabolite, resulting in increased risk of didanosine-related toxicities including fatal hepatic failure, peripheral neuropathy, pancreatitis and symptomatic hyperlactatemia/lactic acidosis.

Conflict Code: DD – Drug/Drug Interactions

Util A	Util B	Util C
Didanosine	Ribavirin	

References:

Videx EC Prescribing Information, Nov. 2011, Bristol-Myers Squibb.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.
Facts & Comparisons, 2012 Updates.

13. Stribild / Non-adherence _____ _____

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

Conflict Code: LR - Nonadherence Drugs/Diseases

Util A	Util B	Util C
Stribild		

References:

Stribild Prescribing Information, August 2012, Gilead Sciences, Inc.
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. March 27, 2012;1-167. Available at: http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf.
Beer L, Heffelfinger J, Frazier E. et al. Use of and Adherence to Antiretroviral Therapy in a Large U.S. Sample of HIV-Infected Adults in Care, 2007-2008. Open AIDS J. 2012;6:213-223.

14. Complera / Non-adherence _____ _____

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

Conflict Code: LR - Nonadherence Drugs/Diseases

Util A	Util B	Util C
Complera		

References:

Complera Prescribing Information, August 2012, Gilead Sciences, Inc.
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. March 27, 2012;1-167. Available at: http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf.
Beer L, Heffelfinger J, Frazier E. et al. Use of and Adherence to Antiretroviral Therapy in a Large U.S. Sample of HIV-Infected Adults in Care, 2007-2008. Open AIDS J. 2012;6:213-223.

15. Complera / All Other Antiretroviral Agents _____ _____

Alert Message: The patient appears to be receiving other antiretroviral therapy in addition to Complera (emtricitabine/tenofovir/rilpivirine). Complera is a complete regimen for the treatment of HIV-1 infections and should not be administered with other antiretroviral medications.

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

Util A	Util B	Util C
Complera	All Other Antiretrovirals	

References:
Complera Prescribing Information, July 2011, Gilead Sciences, Inc.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.