DUR Board Meeting
December 3, 2013
Bismarck State College

National Energy Center of Excellence

North Dakota Medicaid
DUR Board Meeting Agenda
Bismarck State College
National Energy Center of Excellence
Room 431/433
1200 Schafer Street
Bismarck, ND
December 3, 2013
1pm

1. Administrative items
    - Travel vouchers

2. Old business

• Review and Approval of Minutes of 9/13 Meeting	Chair
• Budget Update	Brendan
• Second Review of Sirturo	Brendan
• Second Review of Brisdelle	Brendan
• Second Review of Nitroglycerin Lingual Spray/Sublingual Tablets	Brendan
• Second Review of Agents Used to Treat COPD	Brendan
• Second Review of Epinephrine Auto-Injection Devices	Brendan
• Second Review of Pulmozyme	Brendan
• Review of Statins	Brendan
• Review of Vecamyl	Brendan

3. New business

• Annual PA Review	HID
• Criteria Recommendations	HID
• Upcoming Meeting Date/Agenda	Chair

4. Adjourn — Chair

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

Drug Utilization Review (DUR) Meeting Minutes
September 9, 2013

Members Present: Norman Byers, John Savageau, Cheryl Huber, Greg Pfister, Jeffrey Hostetter, Peter Woodrow, Carlotta McCleary, Carrie Sorenson, Russ Sobotta

Members Absent: Todd Twogood, Leann Ness, Tanya Schmidt, Steve Irsfeld, James Carlson, Michael Booth

Medicaid Pharmacy Department: Brendan Joyce, Gary Betting

HID Staff Present: Candace Rieth

Chair G. Pfister called the meeting to order at 1:00 pm. Chair G. Pfister asked for a motion to approve the minutes from the June meeting. N. Byers moved that the minutes be approved, and G. Betting seconded the motion. Chair G. Pfister called for a voice vote to approve the minutes. The motion passed with no audible dissent. New board member, Peter Woodrow was introduced to the Board.

Budget Update
B. Joyce informed the board members that for the 2011-2013 biennium, the net spend was 37.8 million dollars; 72.9 million dollars spend pre-rebate. There was approximately 35 million collected in rebates. This includes approximately 64,000 recipients and 1.43 million pharmacy claims.

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

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

Sitavig Second Review
A motion and second were made at the June meeting to place Sitavig on prior authorization. The topic was brought up for a second review. There was no public comment. After discussion, Chair G. Pfister called for a voice vote to approve the motion. The motion passed with no audible dissent. This will be added to the Orally Disintegrating Tablets PA form.

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

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

Sirturo Review
B. Joyce reviewed Sirturo clinical information with the board. There was no public comment. J. Hostetter made a motion to make Sirturo unavailable in the retail setting. C. Huber seconded the motion. This topic will be brought up at the next meeting for finalization.

Brisdelle Review
B. Joyce reviewed Brisdelle clinical information with the board. There was no public comment. N. Byers made a motion to place Brisdelle on prior authorization. P. Woodrow seconded the motion. This topic will be brought up at the next meeting for finalization.

Vecamyl Review
B. Joyce reviewed Vecamyl clinical information with the board. There was no public comment. J. Hostetter made a motion to review more information at the December meeting. G. Pfister seconded the motion. This topic will be reviewed at the next meeting.

Nitroglycerin Lingual Spray/Sublingual Tablet Review
B. Joyce reviewed nitroglycerin spray/sublingual tablet clinical information with the board. There was no public comment. P. Woodrow made a motion to place Nitroglycerin Lingual Spray on prior authorization. J. Savageau seconded the motion. This topic will be brought up at the next meeting for finalization.

COPD Review
B. Joyce reviewed agents used to treat COPD clinical information with the board. There was no public comment. J. Savageau made a motion to place agents used to treat COPD on prior authorization. P. Woodrow seconded the motion. This topic will be brought up at the next meeting for finalization.

Epinephrine Auto-Injections Review
B. Joyce reviewed epinephrine auto-injections clinical information with the board. R. Sobotta, representing Sanofi, spoke regarding Auvi Q. N. Byers made a motion to place epinephrine auto-injectors on prior authorization. G. Pfister seconded the motion. The department will review post rebate data to determine which drug is the best option (EpiPen or Auvi Q). This topic will be brought up at the next meeting for finalization.

Pulmozyme Review
B. Joyce reviewed Pulmozyme clinical information with the board. D. Evans, representing Genentech, spoke regarding Pulmozyme. J. Hostetter made a motion to place Pulmozyme on prior authorization. J. Savageau seconded the motion. This topic will be brought up at the next meeting for finalization.

Statin Review
B. Joyce reviewed statin information with the board. This topic was tabled until 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. C. Huber moved to approve the new criteria and N. Byers seconded the motion. Chair G. Pfister called for a voice vote. The motion passed with no audible dissent.

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

CHAPTER 50-24.6
MEDICAL ASSISTANCE DRUG USE REVIEW AND AUTHORIZATION

50-24.6-01. Definitions.

As used in this chapter, unless the context otherwise requires:

1. "Board" means the drug use review board.
2. "Compendium" means the American hospital formulary service drug information, United States pharmacopeia-drug information, the DRUGDEX information system, American medical association drug evaluations, or nonproprietary peer-reviewed medical literature.
3. "Department" means the department of human services.
4. "Drug use review" means a program as described in 42 U.S.C. 1396r-8(g)(2).
5. "Drug use review criteria" means standards approved by the board for use in determining whether use of a drug is likely to be medically appropriate, to be medically necessary, and not result in adverse medical outcomes.
6. "Prior authorization" means a process requiring the prescriber or the dispenser to verify with the department or the department's contractor that proposed medical use of a particular drug for a medical assistance program recipient meets predetermined criteria for coverage by the medical assistance program.

50-24.6-02. Drug use review board.

1. The board is established within the department for the implementation of a drug use review program.
2. The board consists of seventeen members. The pharmacy administrator of the department and the medical consultant to the department are ex officio nonvoting board members who shall provide administrative services to the board. A majority of the appointed members must be physicians and pharmacists participating in the medical assistance program. Four or more of the appointed members must have experience with a drug use review process or have participated in programs in which prior authorization is used. The appointed members of the board must be:
   a. Four physicians licensed in this state and actively engaged in the practice of medicine, one of whom is a psychiatrist, appointed by the North Dakota medical association;
   b. Two physicians licensed in this state and actively engaged in the practice of medicine, appointed by the executive director of the department;
   c. Four pharmacists licensed in this state and actively engaged in the practice of pharmacy, appointed by the North Dakota pharmaceutical association;
   d. Two pharmacists licensed in this state and actively engaged in the practice of pharmacy, appointed by the executive director of the department;
   e. One individual who represents consumer interests, appointed by the governor;
   f. One pharmacist or physician representing the brand pharmaceutical industry appointed by the pharmaceutical research and manufacturers of America; and
   g. One pharmacist or physician representing the generic pharmaceutical industry appointed by the generic pharmaceutical association.
3. Appointed board members shall serve staggered three-year terms. An appointed member may be reappointed for a period not to exceed three 3-year terms. A vacancy on the board must be filled for the balance of the unexpired term from the appropriate board category as provided under subsection 2. The executive director of the department may replace an appointed member of the board who fails to attend three consecutive meetings of the board without advance excuse or who fails to perform the duties expected of a board member. The pharmaceutical industry representatives are nonvoting board members.
4. Voting board members shall select a chairman and a vice chairman on an annual basis from the board's voting membership.
5. The board shall meet in person at least once every three months and may meet at other times by teleconference or electronically at the discretion of the chairman. A

board member is entitled to receive from the department per diem compensation and reimbursement of expenses as determined by the department, except that no compensation under this section may be paid to any board member who receives compensation or salary as a state employee or official.

50-24.6-03. Duties of the board.

The board shall:

1. Cooperate with the department to create and implement a prospective and retrospective drug use review program for outpatient prescription drugs under the medical assistance program. This drug use review program must be based on a compendium and drug use review criteria and must comply with 42 U.S.C. 1396r-8(g)(3).
2. Advise and make recommendations regarding any rule proposed for adoption by the department to implement the provisions of state and federal law related to drug use review.
3. Receive and consider information regarding the drug use review process which is provided by the department and by interested parties, including prescribers who treat significant numbers of patients under the department's medical assistance program.
4. Review and recommend to the department any drugs to be included on prior authorization status.
5. Review no less than once each year the status of the list of drugs that have been placed on prior authorization.
6. Review and approve the prior authorization program process used by the department, including the process to accommodate the provision of a drug benefit in an emergency situation.
7. Propose remedial strategies to improve the quality of care and to promote effective use of medical assistance program funds or recipient expenditures.

50-24.6-04. Prior authorization program.

1. The department shall develop and implement a prior authorization program that meets the requirements of 42 U.S.C. 1396r-8(d) to determine coverage of drug products when a medical assistance recipient's health care provider prescribes a drug that is identified as requiring prior authorization. Authorization must be granted for provision of the drug if:
   a. The drug not requiring prior authorization has not been effective, or with reasonable certainty is not expected to be effective, in treating the recipient's condition;
   b. The drug not requiring prior authorization causes or is reasonably expected to cause adverse or harmful reactions to the health of the recipient; or
   c. The drug is prescribed for a medically accepted use supported by a compendium or by approved product labeling unless there is a therapeutically equivalent drug that is available without prior authorization.
2. For any drug placed on the prior authorization program, the department shall provide medical and clinical criteria, cost information, and utilization data to the drug use review board for review and consideration. The board may consider department data and information from other sources to make a decision about placement of the drug on prior authorization.
3. Except for quantity limits that may be no less than the pharmaceutical manufacturer's package insert, or brand name drugs with a generic equivalent drug for which the cost to the state postrebate is less than the brand name drugs, in the aggregate, the department may not prior authorize the following medication classes:
   a. Antipsychotics;
   b. Antidepressants;
   c. Anticonvulsants;
   d. Antiretrovirals, for the treatment of human immunodeficiency virus;
   e. Antineoplastic agents, for the treatment of cancer; and

f. Stimulant medication used for the treatment of attention deficit disorder and attention deficit hyperactivity disorder.

4. The department may use contractors to collect and analyze the documentation required under this section and to facilitate the prior authorization program.
5. The department shall consult with the board in the course of adopting rules to implement the prior authorization program. The rules must:
   a. Establish policies and procedures necessary to implement the prior authorization program.
   b. Develop a process that allows prescribers to furnish documentation required to obtain approval for a drug without interfering with patient care activities.
   c. Allow the board to establish panels of physicians and pharmacists which provide expert guidance and recommendations to the board in considering specific drugs or therapeutic classes of drugs to be included in the prior authorization program.

50-24.6-05. Public notice - Applicability.

1. The department shall provide thirty days' notice of all meetings of the board. The notice requirement is met if the department provides notice of the meeting on the department's website and provides, by written or electronic means, individual notice to each person that has requested such notice. If the meeting agenda includes board consideration of a change to the prior authorization program, the department shall include in the notice a list of the affected drugs, and upon request the board shall provide background information. Any interested party may attend a meeting of the board and provide information or recommendations related to the inclusion of a drug in a prior authorization program.
2. The department shall post on the department's website:
   a. The most current and applicable list of drugs requiring prior authorization, together with any limits on coverage of these drugs.
   b. In downloadable format, forms necessary to complete prior authorization requests.
   c. Decisions regarding changes to the prior authorization program list. The department shall allow a period of no less than thirty days for public comment following posting on the website.
   d. Meeting notice.
3. The department may not discontinue the provision of prescription drug benefits being provided to medical assistance recipients before April 14, 2003, based solely on the subsequent placement of the drug on the prior authorization program.

50-24.6-06. Grievances.

Expired under S.L. 2003, ch. 430, § 12.

50-24.6-07. Appeals.

A medical assistance recipient who is aggrieved by the placement of a drug on prior authorization may appeal as authorized under chapter 28-32.

50-24.6-08. Financial incentives prohibited.

The department may not offer or pay, directly or indirectly, any material inducement, bonus, or other financial incentive to a participating provider based on the denial or delay of medically necessary and appropriate prescription drug therapy or based on a reduction in the proportion of recipients who receive prescription drug therapy under the medical assistance program.

50-24.6-09. Maximum allowable costs and use of edits.

To promote efficiency and savings in the department's service to eligible medical assistance program recipients, the department shall create and implement the broadest possible list of drugs that can be paid at the maximum allowable costs. To further promote efficiency and savings, the department shall maximize use of edit programs that pertain to payment of medical

assistance program pharmaceutical claims. Upon request of a member of the legislative assembly, the department shall provide to that member a summary of edit programs available to the medical assistance program and a description of the department's progress in implementing the edit programs.

50-24.6-10. Adoption of rules.

The department shall adopt rules to implement this chapter.

Medicaid Provider Information

Pharmacy Provider Drug Utilization Review Board

Members

Health Information Designs (HID) - North Dakota DUR/PA website

The HID Website for ND Medicaid also contains the DUR Board Meeting Agenda & Minutes, along with the Policy and Procedures.

Per federal law, each state must establish a Drug Use Review (DUR) Board. North Dakota Medicaid's DUR Board has been active for many years. The DUR Board's functions include but are not limited to serving as an advisory board for various policies, identifying and developing educational topics for practitioners to improve drug therapy, and assisting the department in identifying patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care.

The DUR Board includes six physicians, six pharmacists, and three non-voting members as outlined by State Law and Administrative Rules. Meetings are held at least quarterly, and the meetings are open to the public. If you have any questions regarding N.D. Medicaid's DUR Board or the Medication Prior Authorization Program, please contact Brendan Joyce, PharmD, Administrator, Pharmacy Services at bjoyce@nd.gov.

DUR Board members serve staggered three year terms with a maximum of three renewals as described in state law. Below is a table showing the current schedule of the staggered terms and the board members serving those terms. All terms begin July 1 and end June 30 of the specified years. The Position column shows the member subset as well as the entity that appointed that member (e.g. RPh DHS 1 is one of two pharmacists appointed by the Department of Human Services). The number of remaining renewals (if applicable) are shown, and the Appointment Ends column is populated with the year the member would end service on the Board if they exhaust all available renewals.

Position	Member Name	Member Type	Appointed Date	Renewals Left	Appointment Ends
Ex-Officio	Betting, Gary, MD	MD		N/A	OPEN
Ex-Officio	Joyce, Brendan, PharmD	Pharm		N/A	OPEN
Gov Appt	McCleary, Carlotta	Cons. Int.	7/1/2006	1	2018
GPhA	Carlson, James, PharmD	GPhA	9/1/2009	2	2021
MD DHS 1	Byers, Norman, MD	MD	7/1/2003	0	2015
MD DHS 2	Woodrow, Peter, MD	MD	7/1/2013	3	2025
MD NDMA 1	Booth, Michael, MD	MD	12/1/2012	3	2024
MD NDMA 2	Hostetter, Jeffrey, MD	MD	9/1/2007	1	2019
MD NDMA 3	Huber, Cheryl, MD	MD	7/1/2004	0	2014
MD NDMA 4	Twogood, Todd, MD	MD	5/1/2006	1	2017
PhRMA	Sobotta, Russ, PhRMA	PhRMA	7/1/2009	2	2018
RPh DHS 1	Ness, Leann, PharmD	Pharm	7/1/2003	0	2015
RPh DHS 2	Pfister, Greg, PharmD	Pharm	7/1/2003	0	2014
RPh NDPhA 1	Irsfeld, Steve, RPh	Pharm	7/1/2009	1	2019
RPh NDPhA 2	Savageau, John, RPh	Pharm	7/1/2003	0	2015
RPh NDPhA 3	Schmidt, Tanya, PharmD	Pharm	4/1/2012	2	2022
RPh NDPhA 4	Sorenson, Carrie, PharmD	Pharm	7/1/2004	0	2014

Top of page Back to previous page

Sirturo
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 Sirturo must meet the following criteria:

- *Sirturo cannot be billed for outpatient use*
- *Sirturo must be billed by physician*

Part I: TO BE COMPLETED BY PHYSICIAN

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

QUALIFICATIONS FOR COVERAGE:

Requested Drug and Dosage: □ **Sirturo**	Diagnosis for this request:
SIRTURO MUST BE GIVEN/BILLED BY PHYSICIAN	
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)	

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Brisdelle
Prior Authorization

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

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

- *Patient must first try paroxetine*

Part I: TO BE COMPLETED BY PHYSICIAN

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

QUALIFICATIONS FOR COVERAGE:	
Requested Drug and Dosage: □ **Brisdelle**	Diagnosis for this request:
Failed Therapy:	Start Date: End Date:
Physician Signature	Date

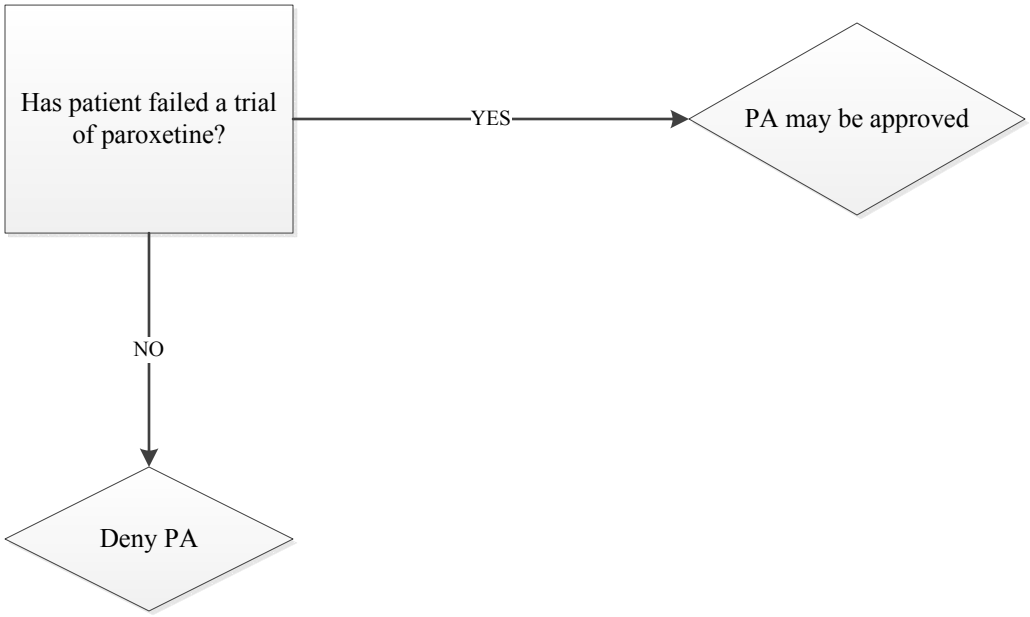
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Brisdelle Authorization Algorithm



HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Nitrolingual Spray
Prior Authorization

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

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

- *Patient must first try sublingual tablets*

Part I: TO BE COMPLETED BY PHYSICIAN

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

QUALIFICATIONS FOR COVERAGE:	
Requested Drug and Dosage: □ **Nitrolingual Spray**	Diagnosis for this request:
Failed Therapy:	Start Date: End Date:
Physician Signature	Date

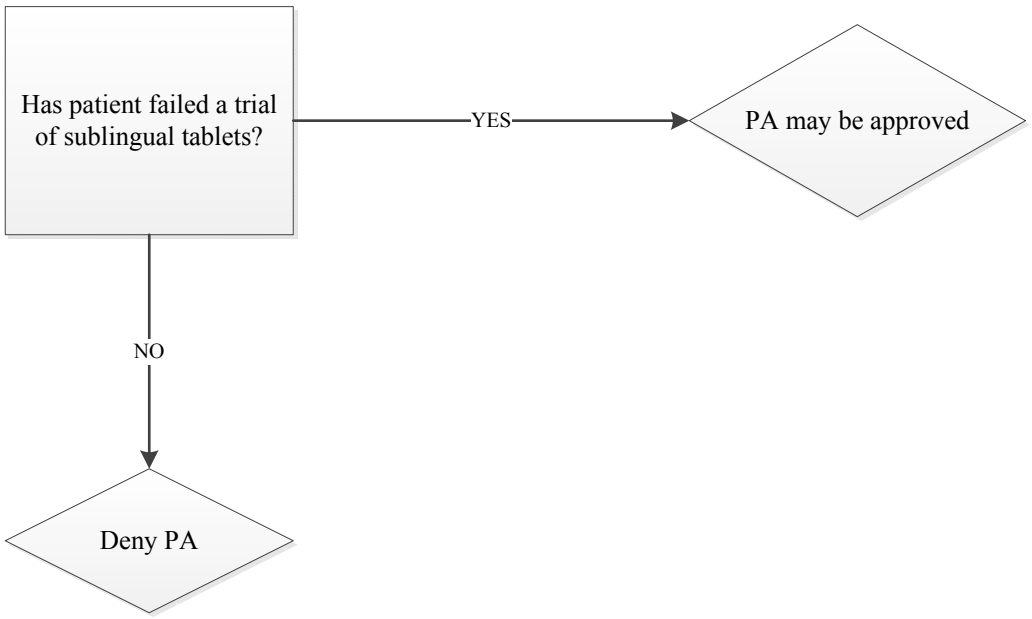
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Nitrolingual Spray Authorization Algorithm



HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Agents Used to Treat COPD
Prior Authorization

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

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

- *Patient must have a diagnosis of COPD.*

Part I: TO BE COMPLETED BY PHYSICIAN

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

QUALIFICATIONS FOR COVERAGE:

Requested Drug and Dosage:	Diagnosis for this request:
□ **Arcapta** □ **Tudorza** □ **Brovana** □ **Breo Ellipta** □ **Spiriva**	
Physician Signature	Date

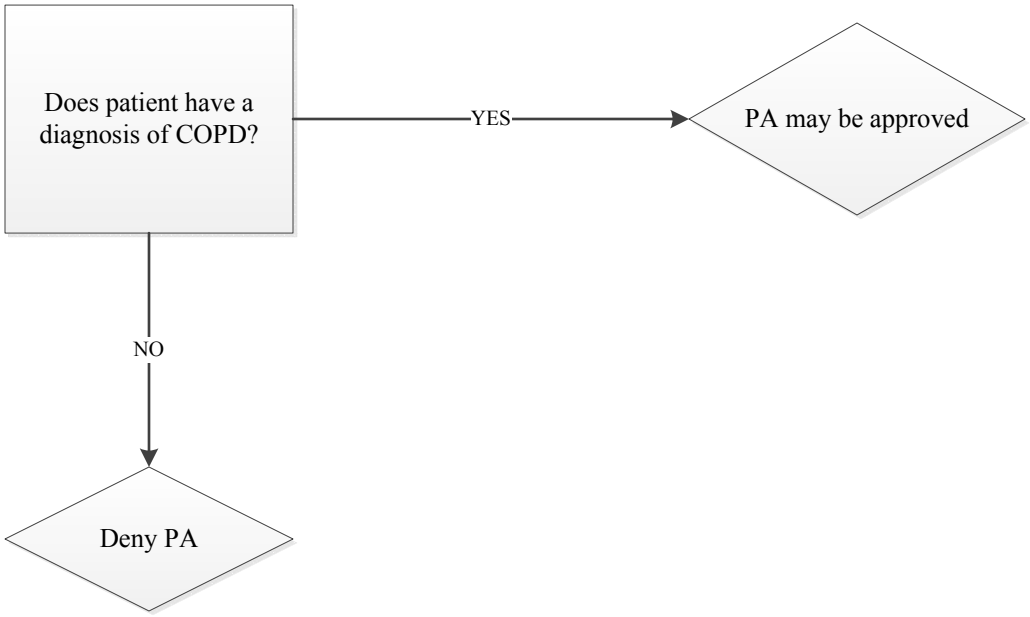
Part II: TO BE COMPLETED BY PHARMACY

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
Agents Used to Treat COPD
Authorization Algorithm



Epinephrine Auto Injectors
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 epinephrine auto injectors must use Auvi-Q as first line therapy.

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

Part I: TO BE COMPLETED BY PHYSICIAN

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

QUALIFICATIONS FOR COVERAGE:	
Requested Drug and Dosage: □	Diagnosis for this request:
Failed Therapy:	Start Date: End Date:
Physician Signature	Date

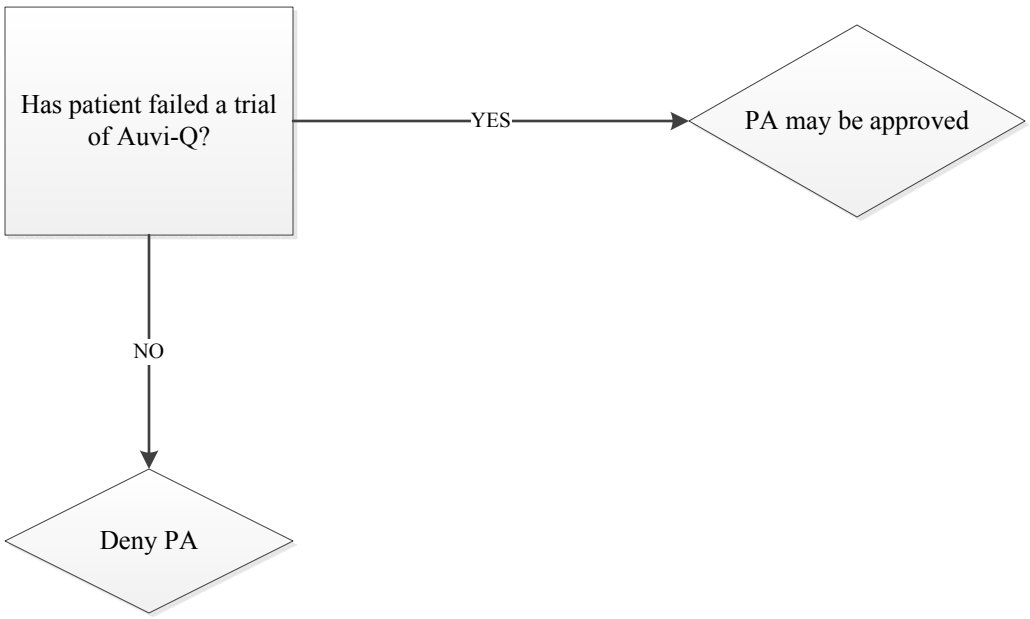
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Epinephrine Auto Injector
Authorization Algorithm



HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Pulmozyme
Prior Authorization

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

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

- *Patient must have a confirmed diagnosis of cystic fibrosis*

Part I: TO BE COMPLETED BY PHYSICIAN

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

QUALIFICATIONS FOR COVERAGE:

Requested Drug and Dosage: □ **Pulmozyme**	Diagnosis for this request:
Physician Signature	Date

Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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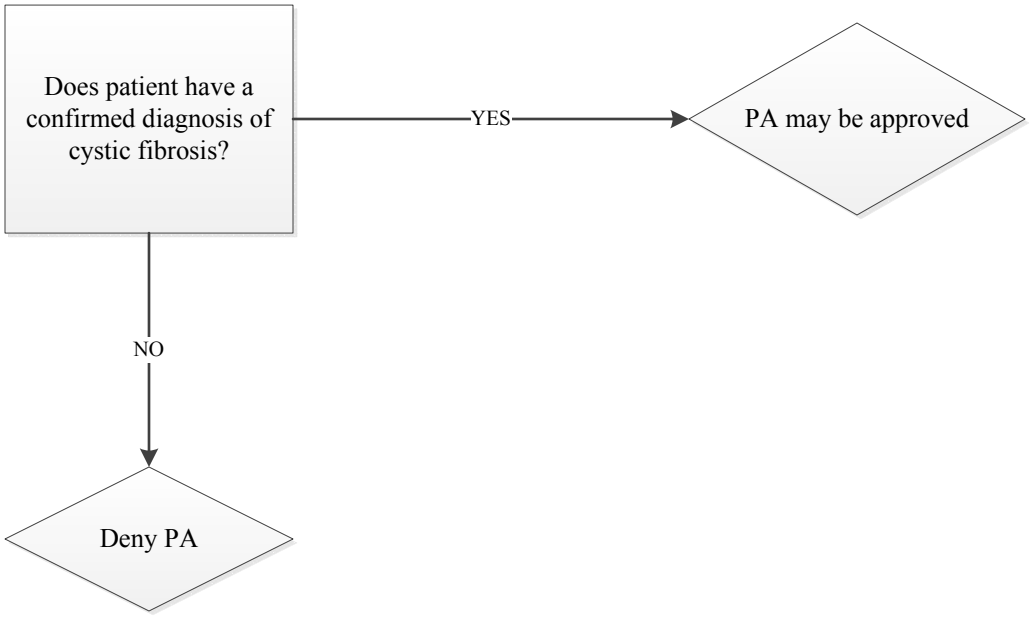
Denied: (Reasons)	

North Dakota Department of Human Services
Pulmozyme Authorization Algorithm



ND Medicaid Statin Utilization (AHFS 240608)			
05/30/12 - 05/29/13			
Label Name	**Rx Num**	**Total Reimb Amt**	**Average Cost per Script**
AMLODIPINE-ATORVAST 10-10 MG	7	$886.34	$126.62
AMLODIPINE-ATORVAST 10-20 MG	4	$684.76	$171.19
AMLODIPINE-ATORVAST 10-40 MG	11	$1,883.09	$171.19
AMLODIPINE-ATORVAST 10-80 MG	12	$2,080.36	$173.36
ATORVASTATIN 10 MG TABLET	64	$662.30	$10.35
ATORVASTATIN 20 MG TABLET	1289	$14,421.53	$11.19
ATORVASTATIN 40 MG TABLET	951	$11,143.43	$11.72
ATORVASTATIN 80 MG TABLET	942	$12,366.17	$13.13
CRESTOR 10 MG TABLET	423	$60,229.98	$142.39
CRESTOR 20 MG TABLET	332	$53,318.16	$160.60
CRESTOR 40 MG TABLET	160	$24,531.76	$153.32
CRESTOR 5 MG TABLET	134	$20,519.91	$153.13
FLUVASTATIN SODIUM 40 MG CAP	2	$206.94	$103.47
LESCOL XL 80 MG TABLET	1	$42.00	$42.00
LIPITOR 20 MG TABLET	1	$25.86	$25.86
LIPITOR 40 MG TABLET	2	$67.15	$33.58
LIVALO 1 MG TABLET	3	$384.84	$128.28
LIVALO 2 MG TABLET	2	$256.56	$128.28
LOVASTATIN 10 MG TABLET	19	$117.59	$6.19
LOVASTATIN 20 MG TABLET	48	$382.38	$7.97
LOVASTATIN 40 MG TABLET	104	$976.93	$9.39
PRAVASTATIN SODIUM 10 MG TAB	54	$528.36	$9.78
PRAVASTATIN SODIUM 20 MG TAB	142	$1,289.32	$9.08
PRAVASTATIN SODIUM 40 MG TAB	214	$2,023.54	$9.46
PRAVASTATIN SODIUM 80 MG TAB	49	$681.70	$13.91
SIMCOR 1,000-20 MG TABLET	6	$1,924.36	$320.73
SIMCOR 500-20 MG TABLET	6	$731.19	$121.87
SIMCOR 500-40 MG TABLET	8	$754.69	$94.34
SIMVASTATIN 10 MG TABLET	702	$4,410.04	$6.28
SIMVASTATIN 20 MG TABLET	1976	$13,270.90	$6.72
SIMVASTATIN 40 MG TABLET	1179	$8,492.59	$7.20
SIMVASTATIN 5 MG TABLET	54	$445.87	$8.26
SIMVASTATIN 80 MG TABLET	209	$1,693.35	$8.10
1,333 recipients	**9112**	**$241,433.95**	

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

HMG-CoA Reductase Inhibitors (Statins) 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 HMG-CoA Reductase Inhibitors must meet the following criteria:

- *Patient must have paid claims that show two trials of generic statins*

Part I: TO BE COMPLETED BY PHYSICIAN

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

QUALIFICATIONS FOR COVERAGE:

Requested Drug and Dosage:	Diagnosis for this request:
Medication Failed and Dose 1._____ Start Date: End Date: 2._____ Start Date: End Date:	
Physician Signature	Date

Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Medicaid
Pharmacotherapy Review
Vecamyl®

I. Indication

Mecamylamine is a potent oral antihypertensive agent and ganglion blocker indicated for the management of moderately severe to severe essential hypertension and uncomplicated cases of malignant hypertension.

II. Dosage and Administration

Therapy is usually started with one 2.5mg tablet mecamylamine twice a day. This initial dosage should be modified by increments of one 2.5mg tablet at intervals of not less than 2 days until the blood pressure response occurs. The average total daily dosage of mecamylamine is 25mg, usually in three divided doses. However, as little as 2.5mg daily may be sufficient to control hypertension in some patients. Close supervision and education of the patient, as well as critical adjustment of dosage, are essential to successful therapy.

III. Contraindications

Mecamylamine should be used in mile, moderate, labile hypertension and may prove unsuitable in uncooperative patients. It is contraindicated in coronary insufficiency or recent myocardial infarction.

Mecamylamine should be given with great discretion, if at all, when renal insufficiency is manifested by a rising or elevated BUN. The drug is contraindicated in uremia. Patients receiving antibiotics and sulfonamides should generally not be treated with ganglion blockers. Other contraindications are glaucoma, organic pyloric stenosis or hypersensitivity to the product.

IV. Warnings and Precautions

Mecamylamine, a secondary amine, readily penetrates into the brain and thus may produce central nervous system effects. Tremor, choreiform movements, mental aberrations, and convulsions may occur rarely. These have occurred most often when large doses of mecamylamine were used, especially in patients with cerebral or renal insufficiency.

When ganglion blockers or other potent antihypertensive drugs are discontinued suddenly, hypertensive levels return. In patients with malignant hypertension and others, this may occur abruptly and may cause fatal cerebral vascular accidents or acute congestive heart failure. When mecamylamine is withdrawn, this should be done gradually and other antihypertensive therapy usually must be substituted. The effects of mecamylamine sometimes may last from hours to days after therapy is discontinued.

The patient's condition should be evaluated carefully, particularly as to renal and cardiovascular function. When renal, cerebral, or coronary blood flow is deficient, any additional impairment, which might result from added hypotension, must be avoided. The use of mecamylamine in patients with marked cerebral and coronary arteriosclerosis or after a recent cerebral accident requires caution.

The action of mecamylamine may be potentiated by excessive heat, fever, infection, hemorrhage, pregnancy, anesthesia, surgery, vigorous exercise, other antihypertensive drugs, alcohol, and salt depletion as a result of diminished intake or increased excretion due to diarrhea, vomiting, excessive sweating, or diuretics.

During therapy with mecamylamine, sodium intake should not be restricted but, if necessary, the dosage of the ganglion blocker must be adjusted.

Since urinary retention may occur in patients on ganglion blockers, caution is required in patients with prostatic hypertrophy, bladder neck obstruction, and urethral stricture.

Frequent loose bowel movements with abdominal distention and decreased borborygmi may be the first signs of paralytic ileus. If these are present, mecamylamine should be discontinued immediately and remedial steps taken.

V. Adverse Reactions

The following adverse reactions have been reported and within each category are listed in order of decreasing severity.

Gastrointestinal: Ileus, constipation (sometimes preceded by small, frequent liquid stools), vomiting, nausea, anorexia, glossitis and dryness of mouth.

Cardiovascular: Orthostatic dizziness and syncope, postural hypotension.
Nervous System/Psychiatric: Convulsions, choreiform movements, mental aberrations, tremor, and paresthesias.

Respiratory: Interstitial pulmonary edema and fibrosis.

Urogenital: Urinary retention, impotence, decreased libido.

Special Senses: Blurred vision, dilated pupils.

Miscellaneous: Weakness, fatigue, sedation.

VI. Drug Interactions

Patients receiving antibiotics and sulfonamides generally should not be treated with ganglion blockers.
The action of mecamylamine may be potentiated by anesthesia, other hypertensive drugs, and alcohol.

VII. Cost

The cost of mecamylamine is approximately 54 dollars per tablet.

Reference

1. Vecamyl® [prescribing information]. Fort Collins, CO. Manchester Pharmaceuticals, Inc.; September 2012.

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, Edarbi and their hydrochlorothiazide containing combinations.**
- **Renin Inhibitor: Tekturna and Tekturna HCT.**

Part I: TO BE COMPLETED BY PRESCRIBER

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

Qualifications for coverage:

□ Failed ACE-I therapy (list two ACE-I to receive Aceon)	Start Date	End Date	Dose	Frequency

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

Prescriber Signature	Date

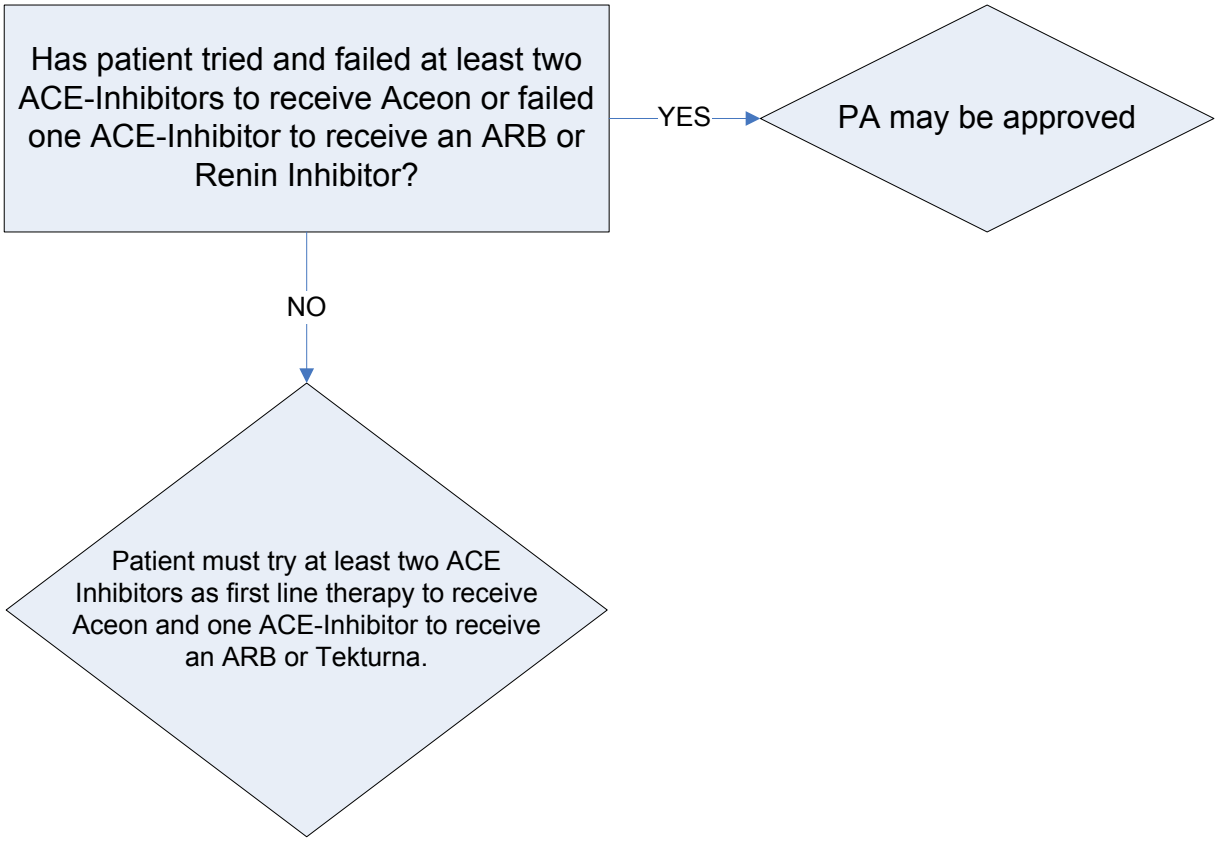
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - 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

ACTINIC KERATOSIS 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 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	

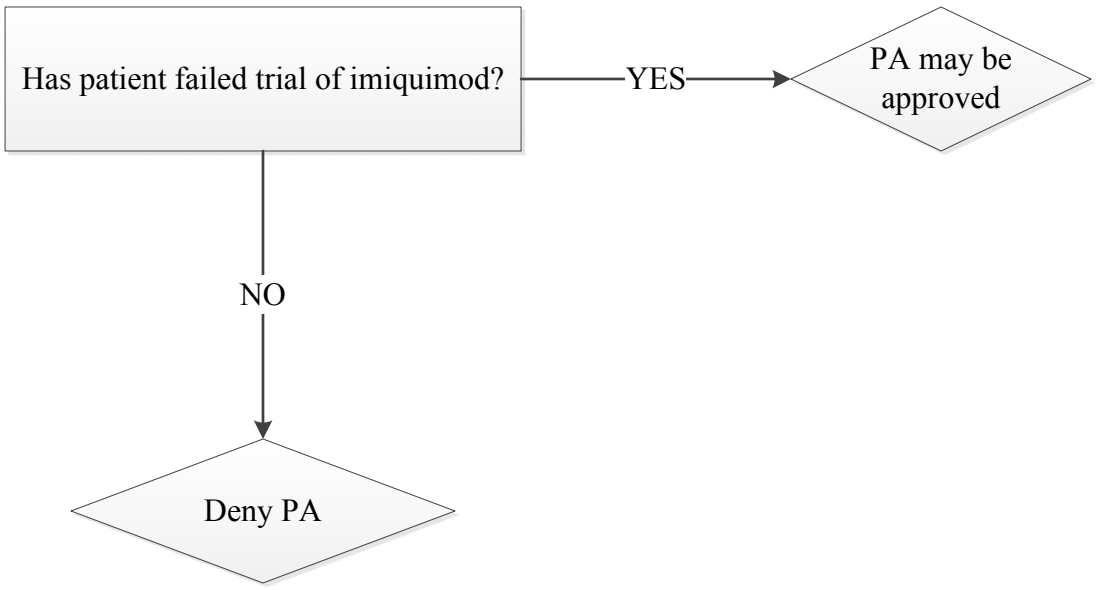
Part II: TO BE COMPLETED BY PHARMACY

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



HEALTH INFORMATION DESIGNS

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	

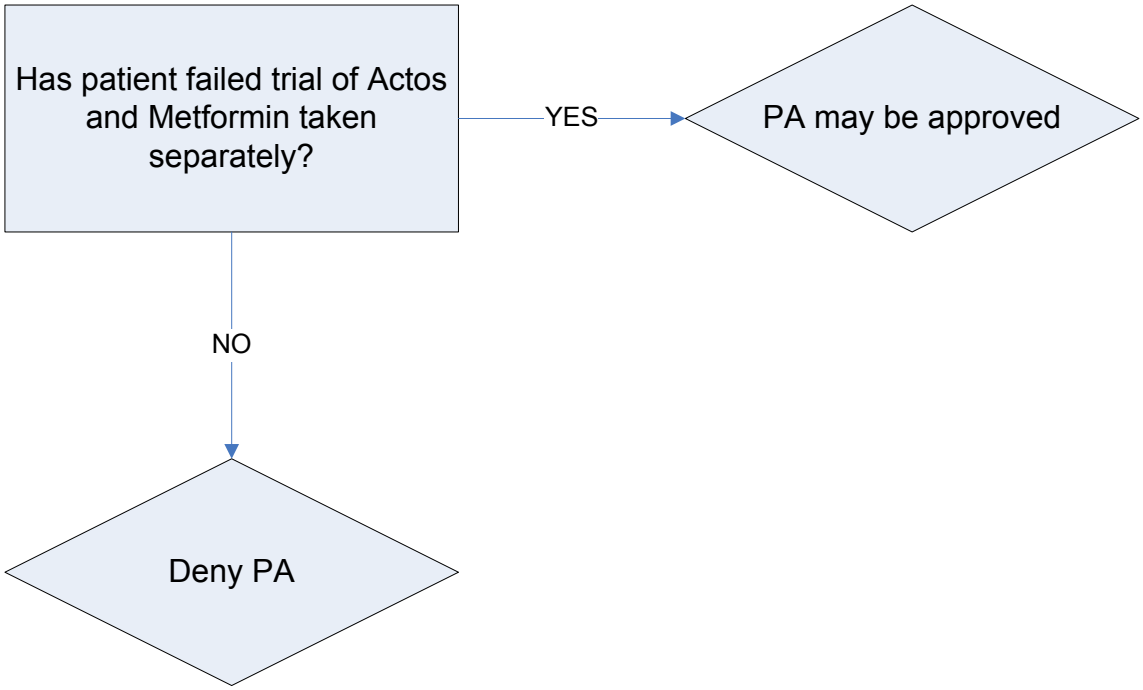
Part II: TO BE COMPLETED BY PHARMACY

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

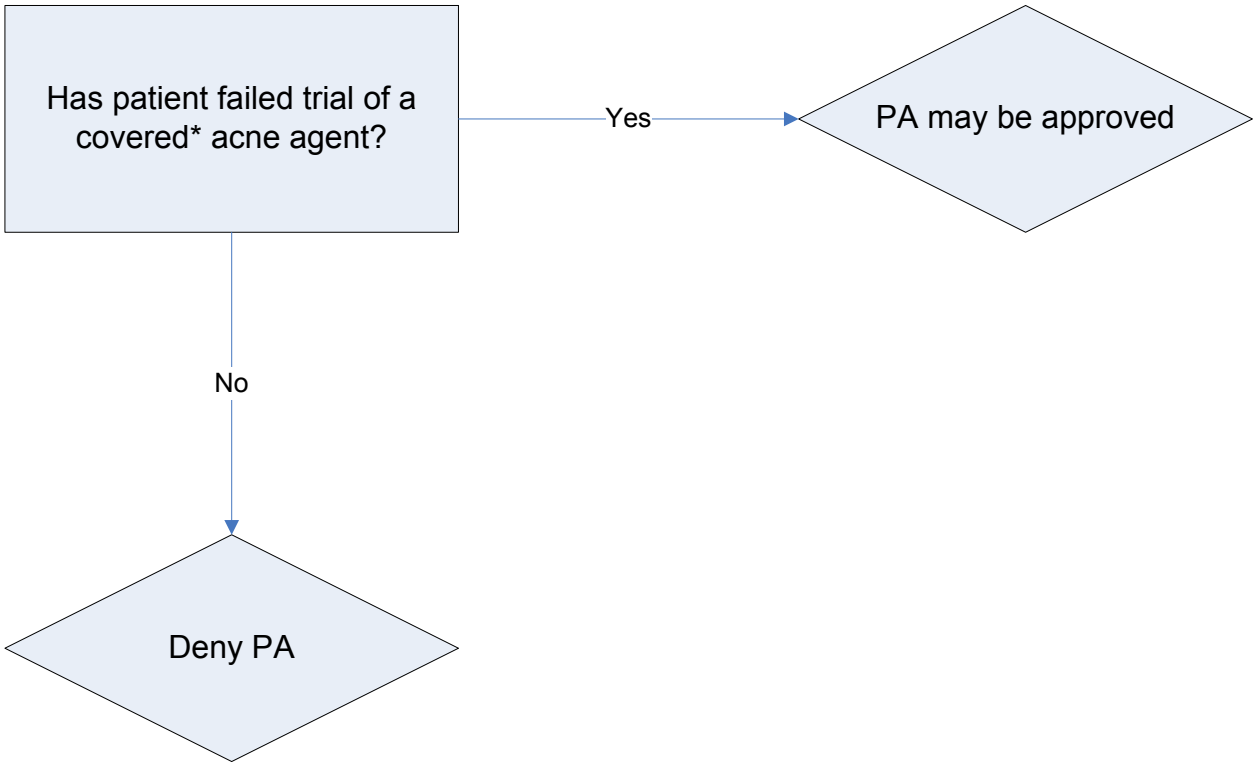
Part II: TO BE COMPLETED BY PHARMACY

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

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	

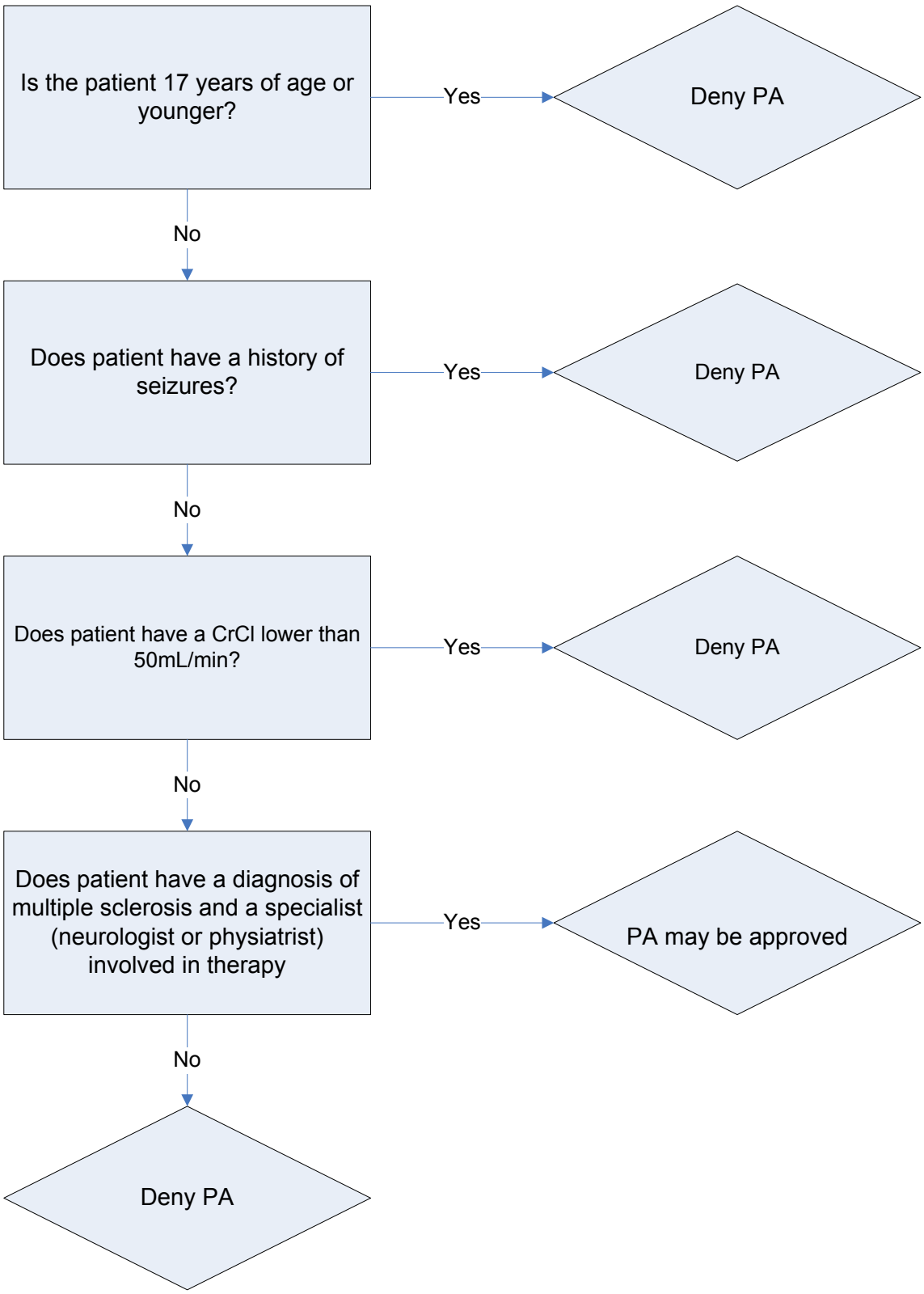
Part II: TO BE COMPLETED BY PHARMACY

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

HEALTH INFORMATION DESIGNS

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: 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:

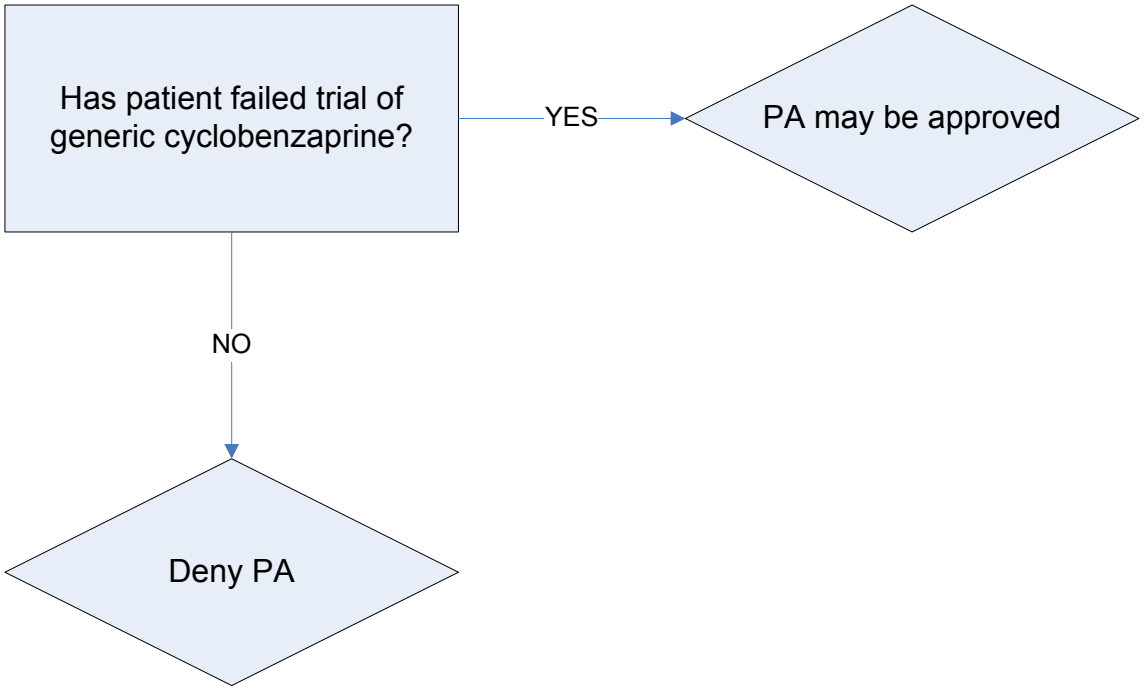
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
Phone:			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:

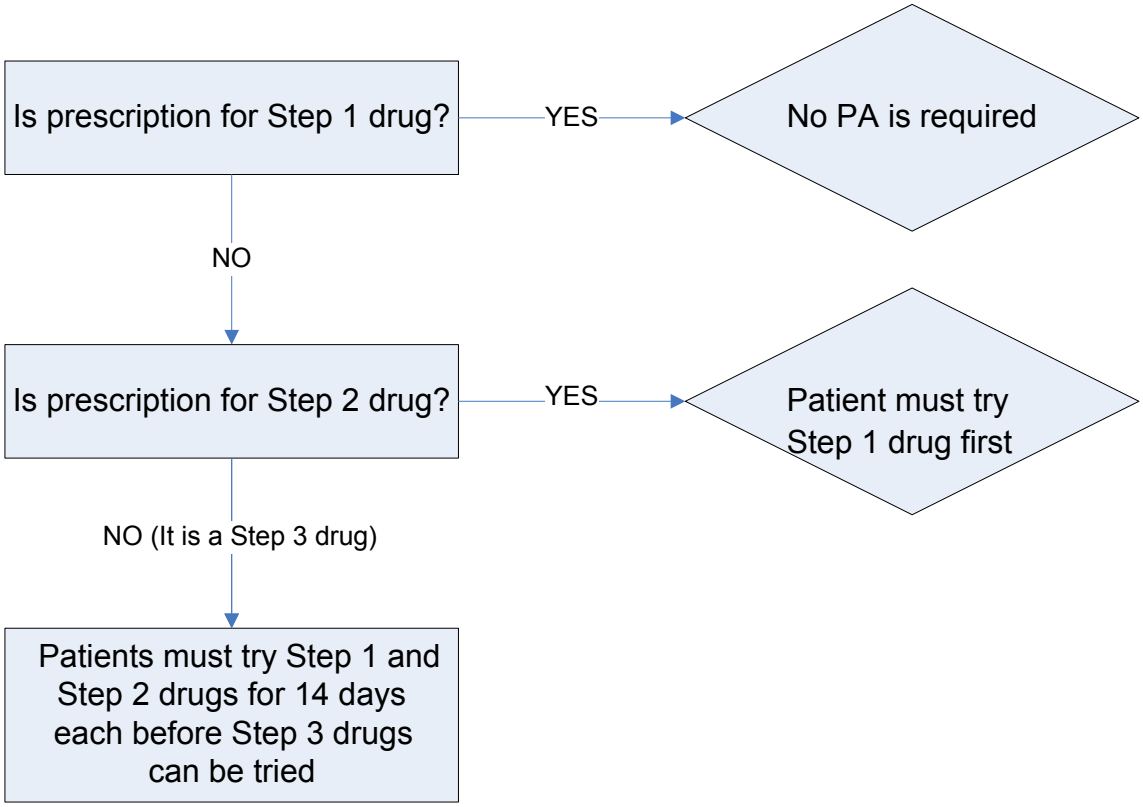
Part II: TO BE COMPLETED BY PHARMACY

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

Aubagio Prior Authorization

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

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed Aubagio must follow these guidelines:

***Note:**

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

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name	Neurologist involved in therapy:		
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Qualifications for coverage:			
Requested Drug and Dosage: □ **Aubagio**	**Diagnosis for this request:**		
Physician Signature		Date	

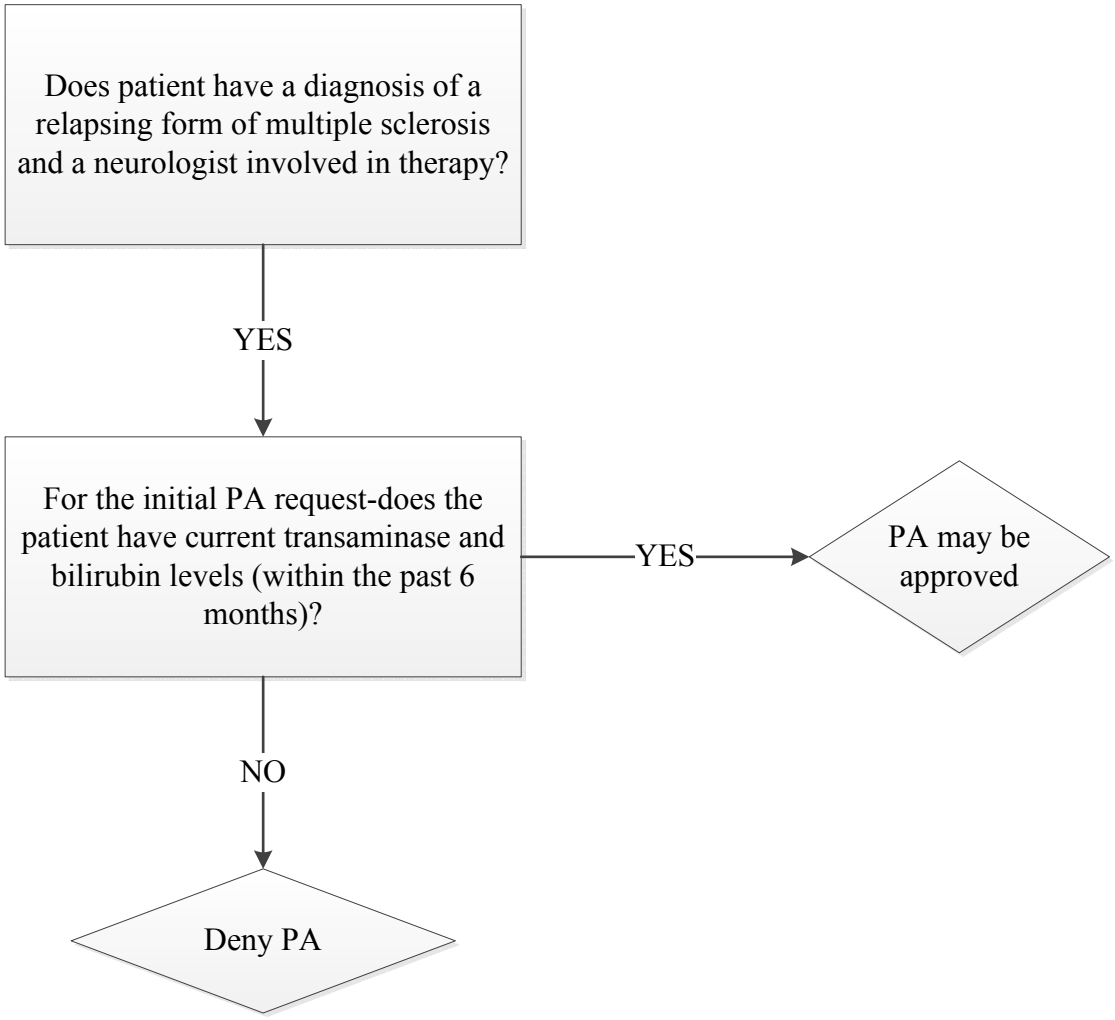
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Aubagio Authorization Algorithm



Aubagio is contraindicated in pregnant women or women of childbearing potential who are not using reliable contraception.

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: END DATE:	DOSE: FREQUENCY:		
Physician Signature		Date	

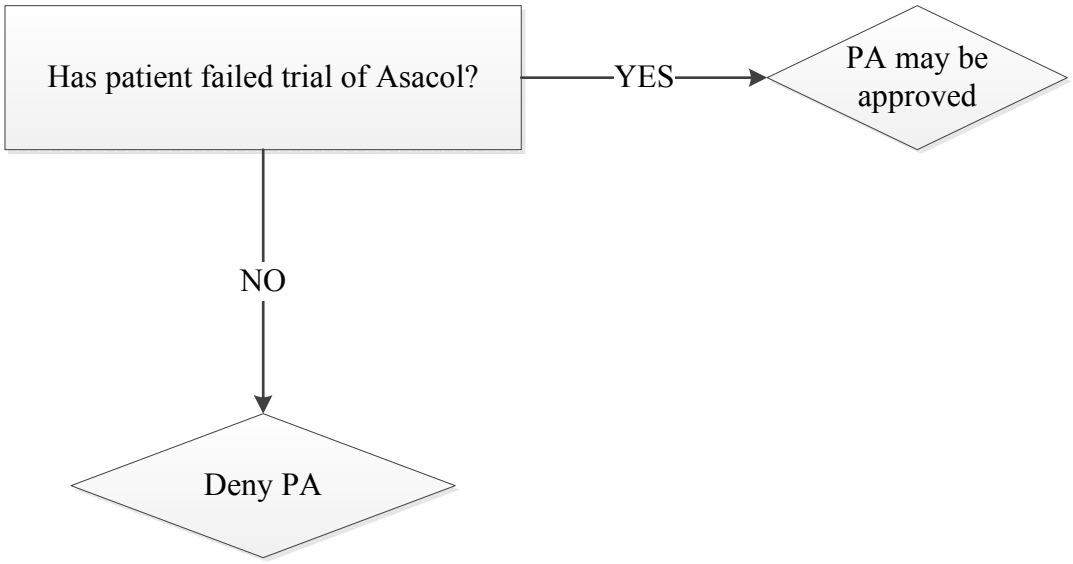
Part II: TO BE COMPLETED BY PHARMACY

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
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

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

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

ND Medicaid requires that patients receiving a new prescription for blood factor products must provide the following information:

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

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
REQUESTED DRUG :	**DOSAGE:**		
Qualifications for coverage:			
TREATMENT CENTER CONTACT INFORMATION:	DATE OF LAST APPOINTMENT WITH TREATMENT CENTER: _____		
Prescriber Signature:		Date:	

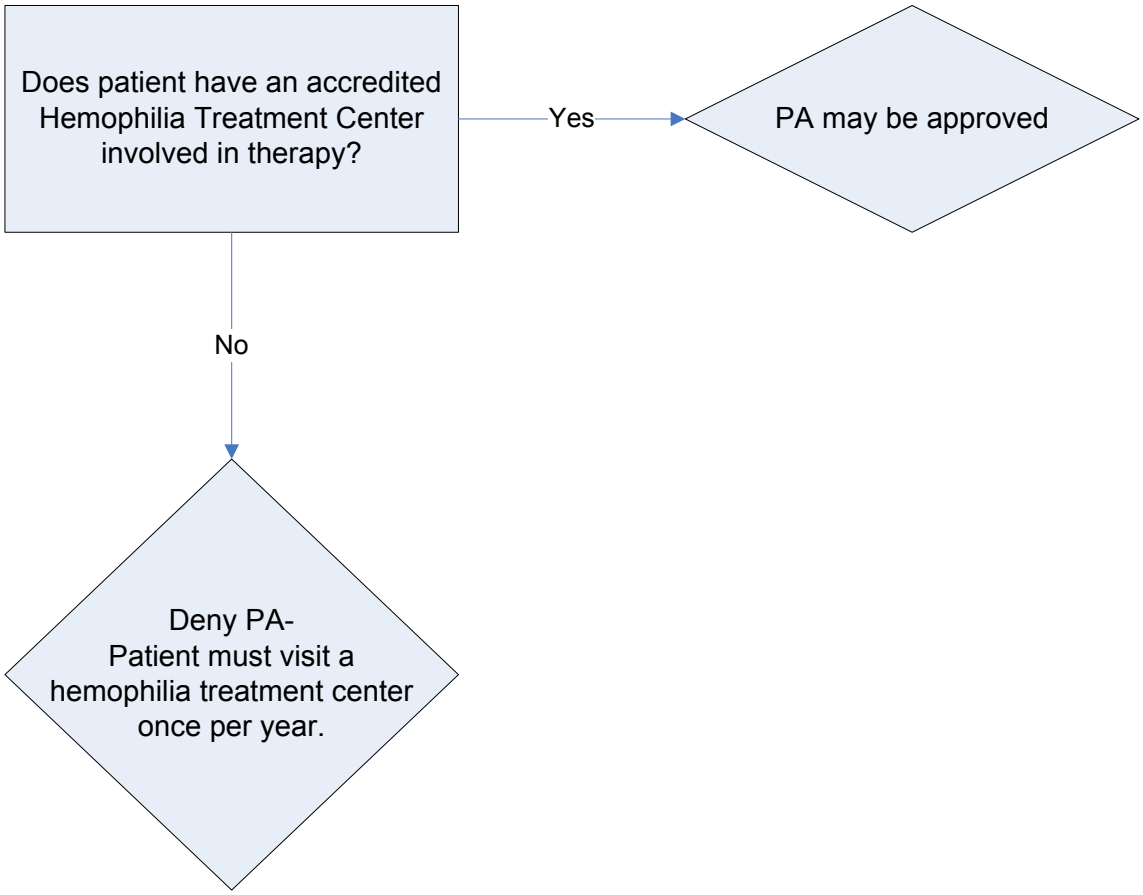
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - 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		

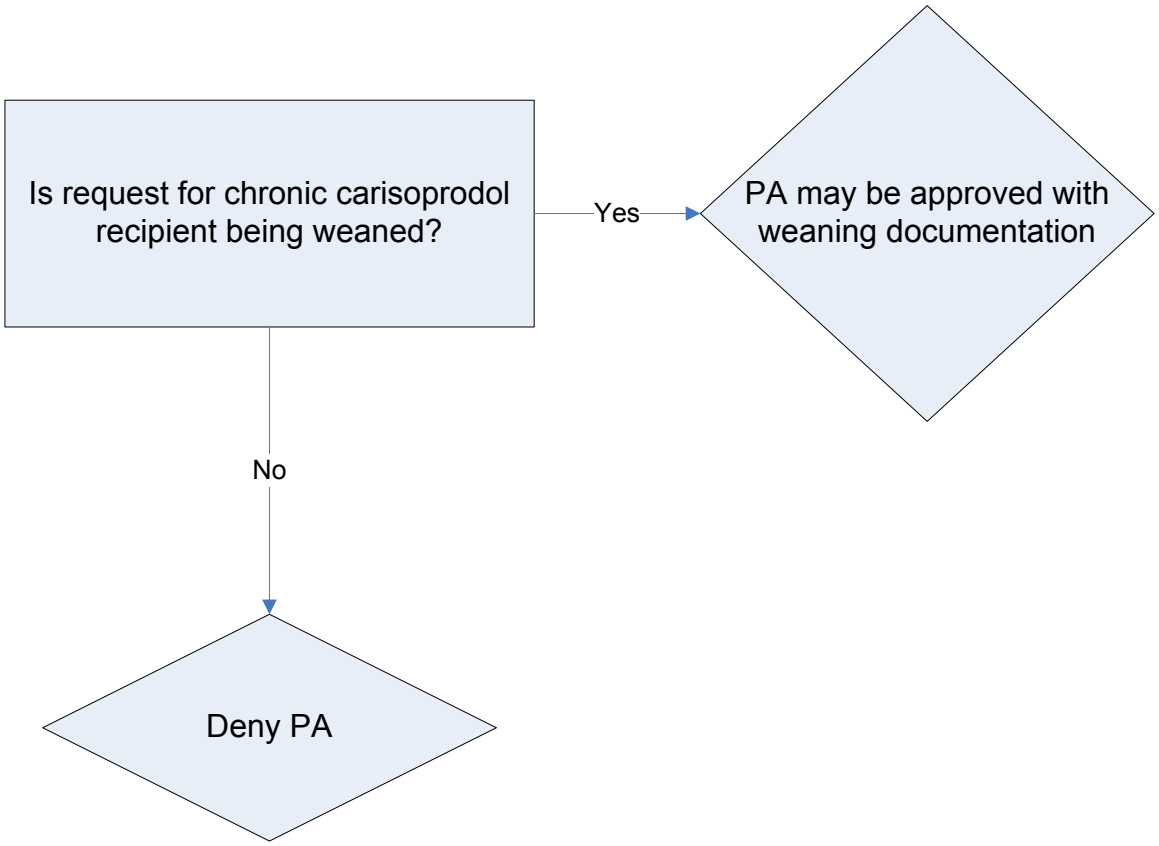
Part II: TO BE COMPLETED BY PHARMACY

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



CIALIS for BENIGN PROSTATIC HYPERPLASIA
PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

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

ND Medicaid requires that patients receiving a prescription for Cialis used to treat benign prostatic hyperplasia (BPH) must meet the following criteria:

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

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this Request:**	**Attach additional notes listing all products failed**	
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber Signature		Date	

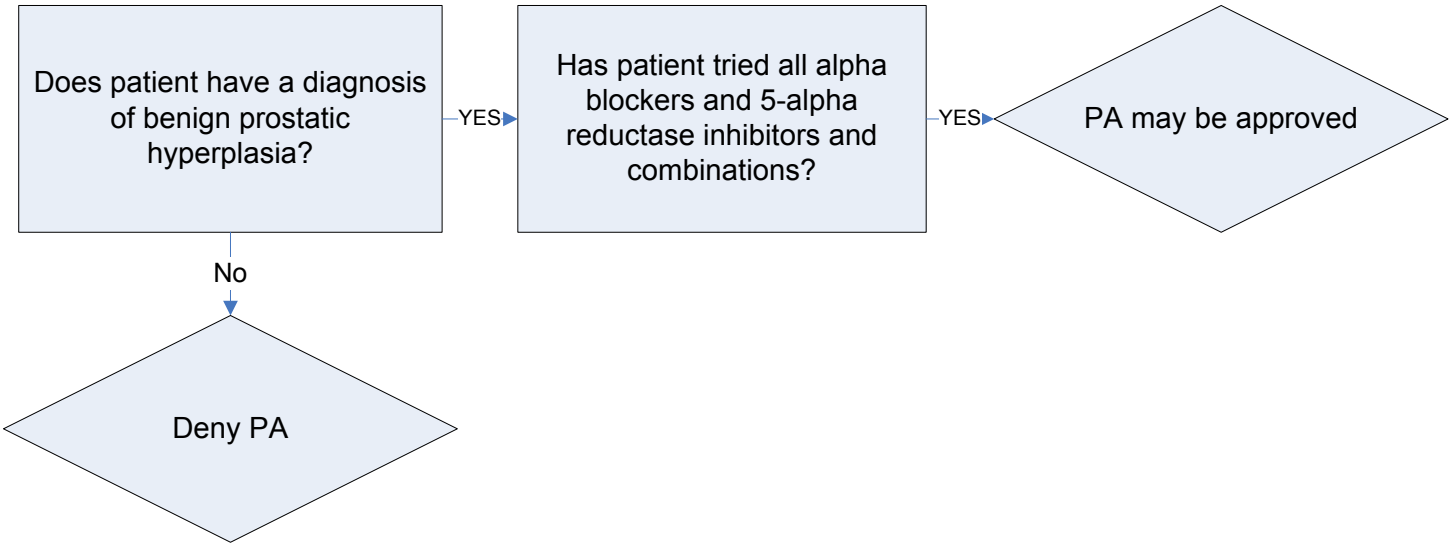
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
CIALIS for Benign Prostatic Hyperplasia
Prior 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	

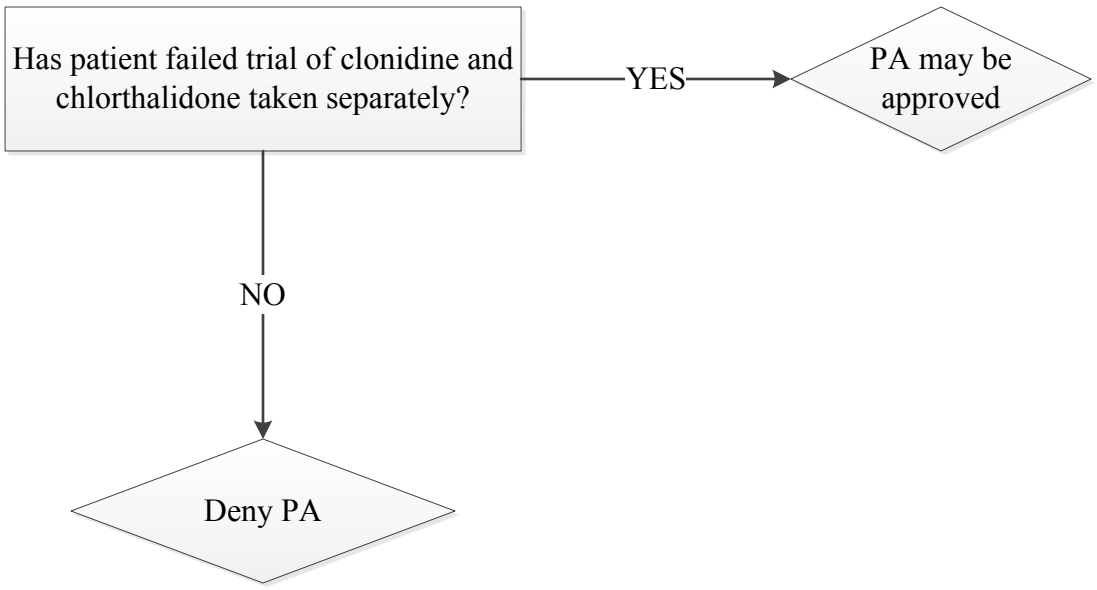
Part II: TO BE COMPLETED BY PHARMACY

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



COMBINATION PRODUCTS
PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

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

ND Medicaid requires that patients receiving a new prescription for a combination product that is more expensive than the individual components must meet the following criteria:

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

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this Request:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber Signature		Date	

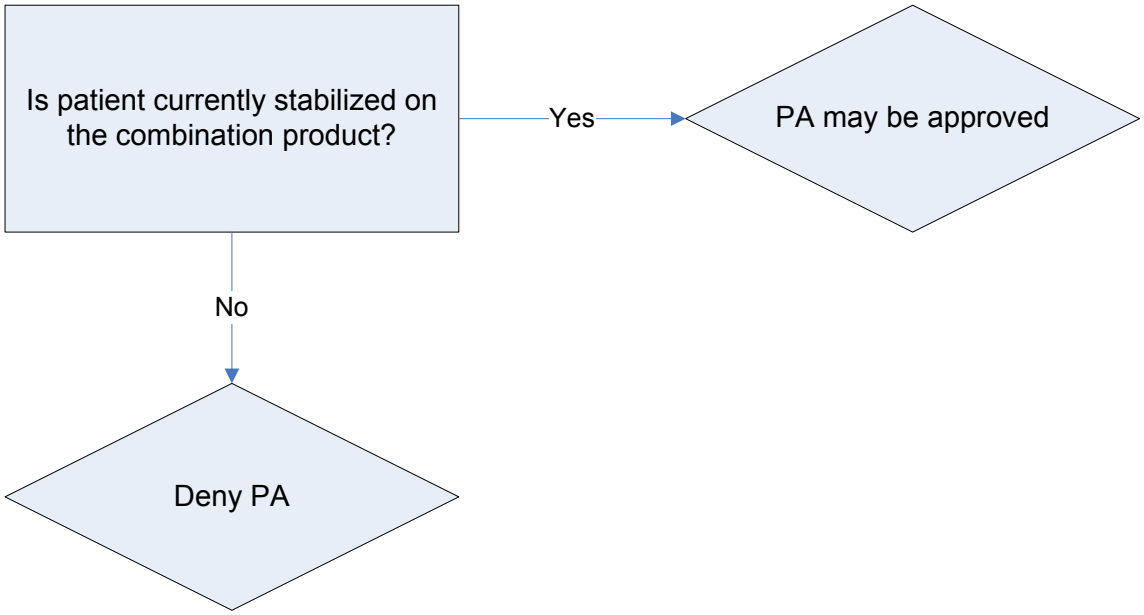
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Combination Products
Prior Authorization Algorithm



HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

BRAND NAME NSAID/COX-II PA FORM

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

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

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

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

Part I: TO BE COMPLETED BY PRESCRIBER

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

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

Qualifications for coverage:

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

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

Prescriber Signature	Date

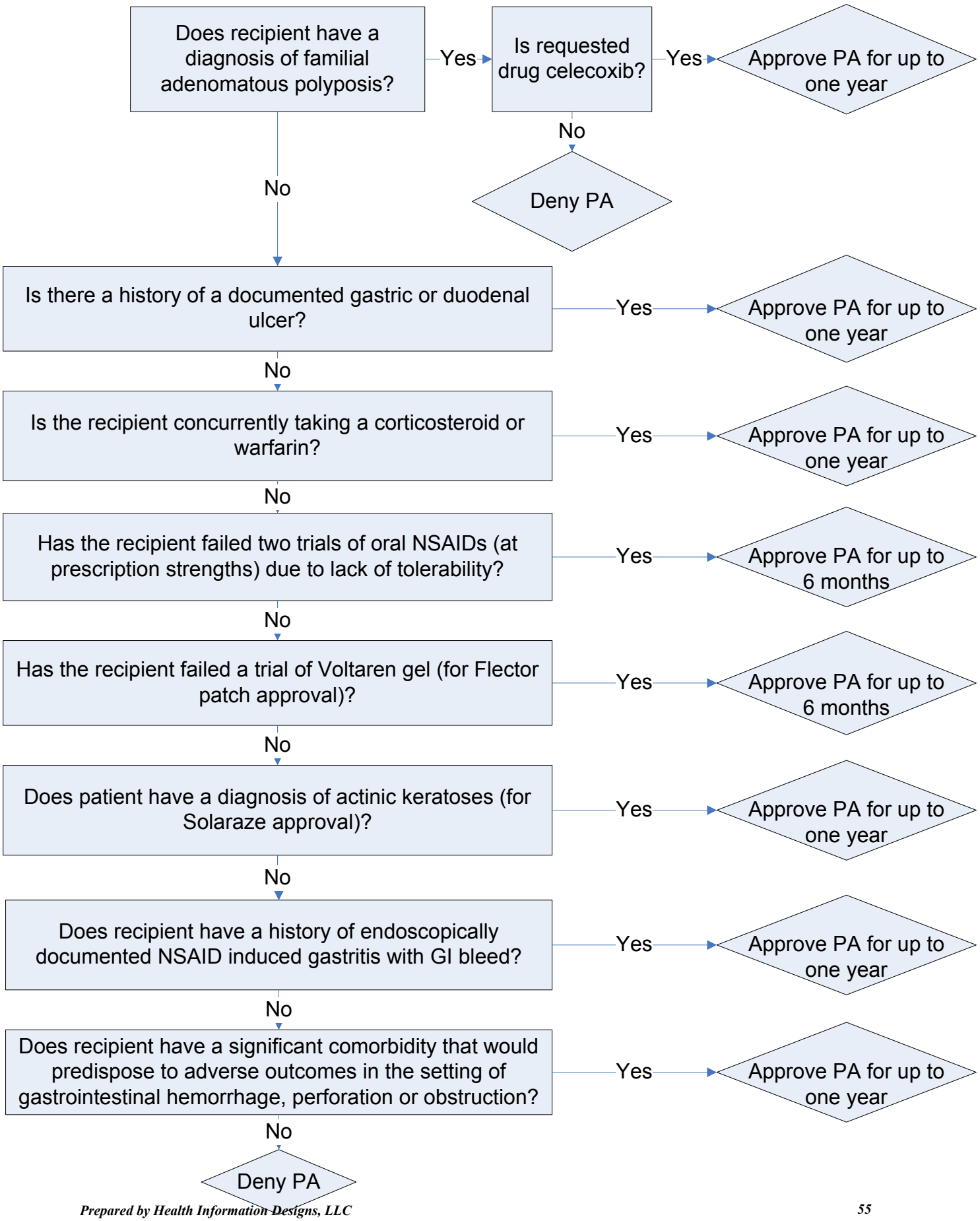
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

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

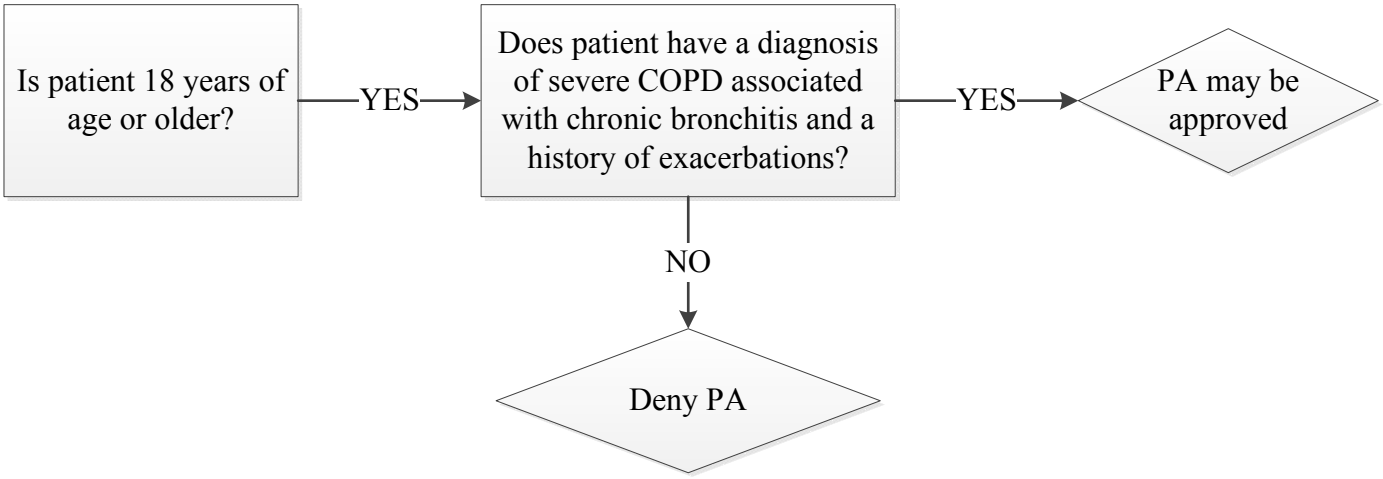
Part II: TO BE COMPLETED BY PHARMACY

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



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)	

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

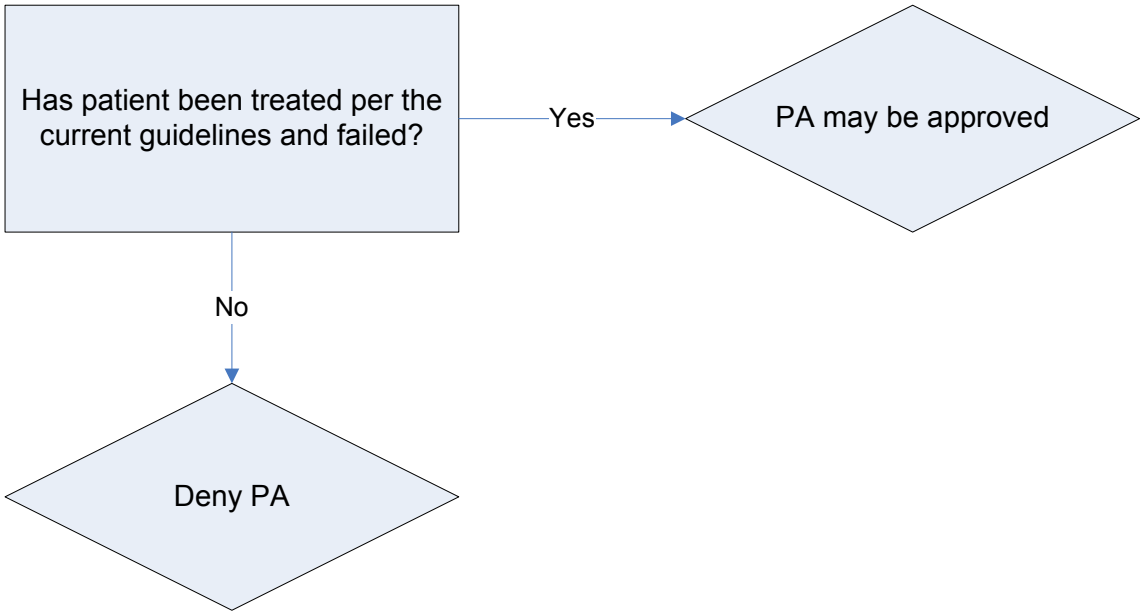
Part II: TO BE COMPLETED BY PHARMACY

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

DEXPAK/ZEMAPAK 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 DexPak or Zema-Pak must meet the following criteria:

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

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ DEXPAK □ ZEMA-PAK	**Diagnosis for this Request:**		
Failed Therapy (dose and frequency): □ DEXAMETHASONE	**Start Date:** **End Date:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber Signature		Date	

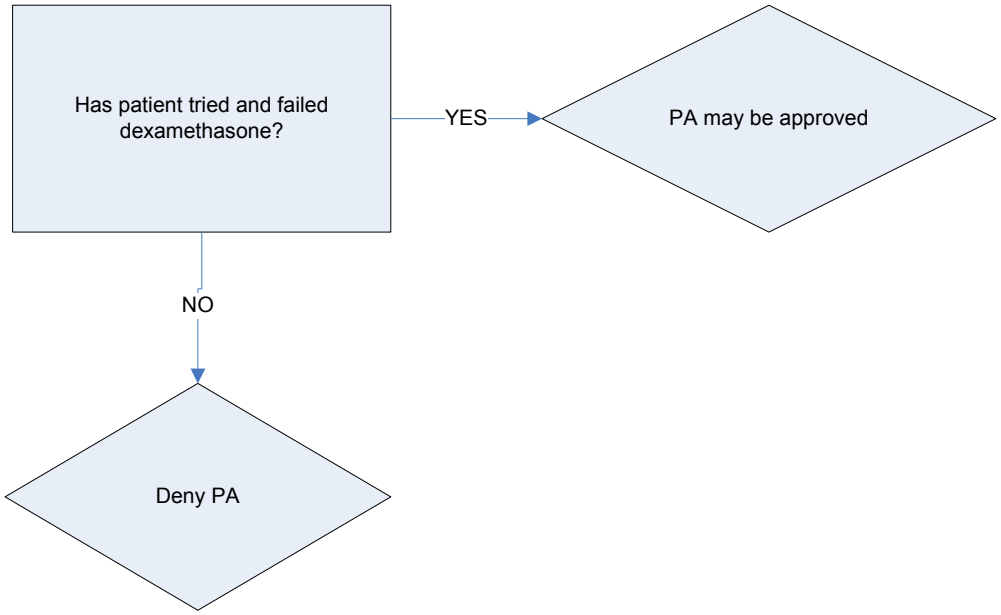
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Dexpak/Zemapak Prior Authorization Algorithm



ELAPRASE 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 Elaprase must meet the following criteria:

- **Patient must have Hunter Syndrome.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ ELAPRASE	**Diagnosis for this Request:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber Signature		Date	

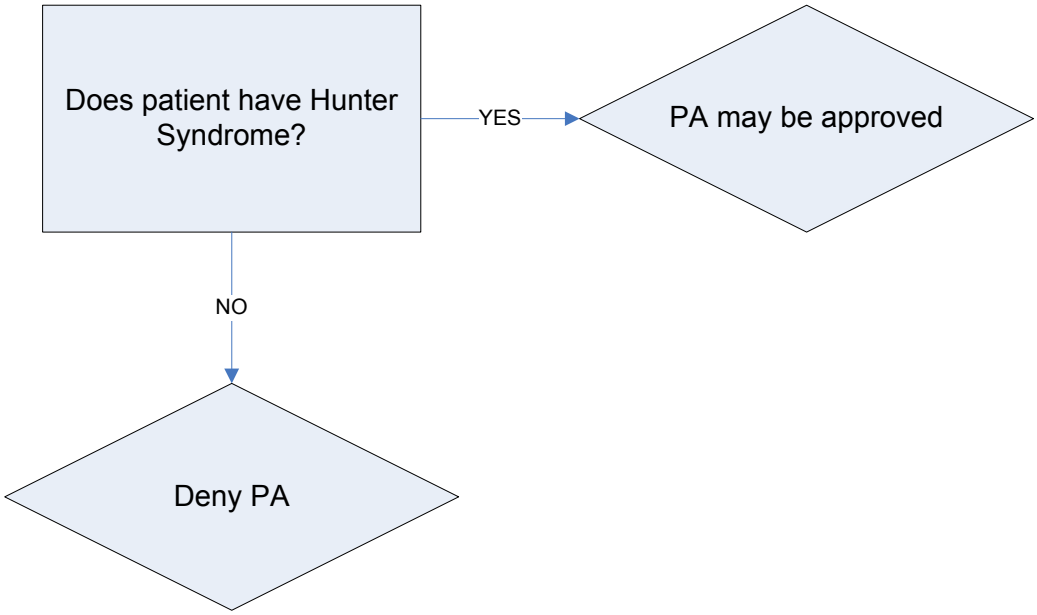
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Elaprase Prior Authorization Algorithm



HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Fulyzaq
Prior Authorization

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

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

Note:

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

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name:			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
QUALIFICATIONS FOR COVERAGE:			
Requested Drug and Dosage: □ **Fulyzaq**	Diagnosis for this request: Anti-retroviral therapy		
Physician Signature	Date		

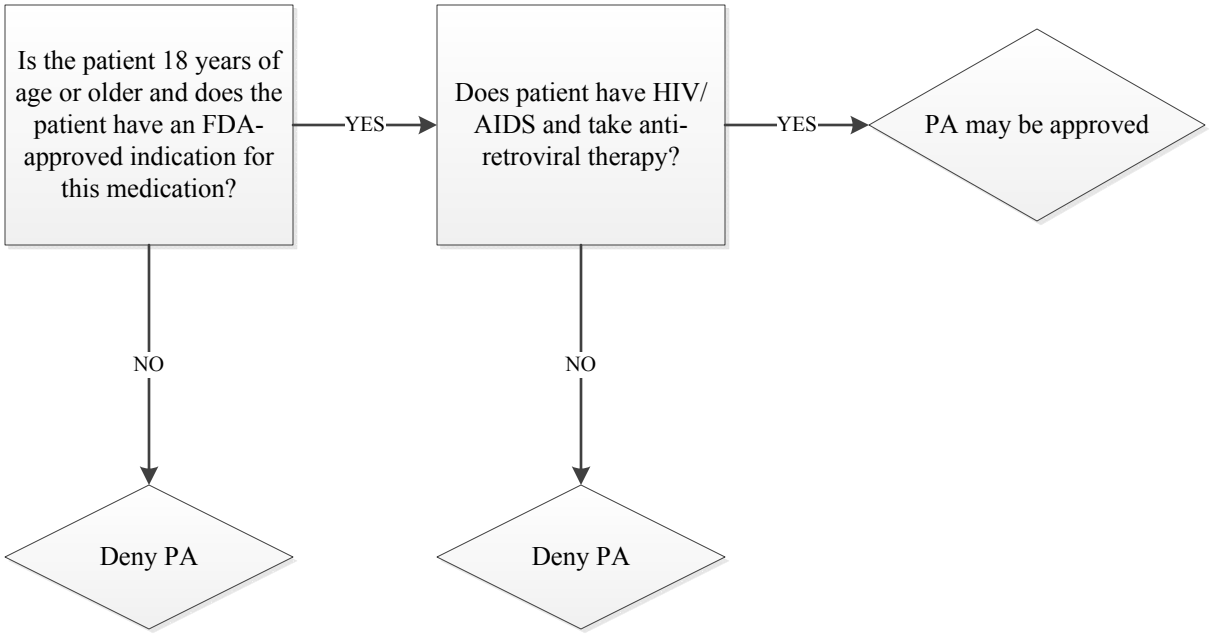
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Fulyzaq Authorization Algorithm



Genitourinary Smooth Muscle Relaxants (GSM) Prior Authorization

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

Prior Authorization Vendor for ND Medicaid

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

Note:

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

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name:			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Qualifications for coverage:			
Requested Drug and Dosage: □ **Enablex** □ **Detrol LA** □ **Toviaz** □ **Gelnique** □ **Myrbetriq** □ **Oxytrol** □ **Detrol** □ **Sanctura** □ **Vesicare** □ **Sanctura XR**	**Diagnosis for this request:** **Failed therapy (Drug and Dose)** **Start Date:** **End Date:**		
Physician Signature		Date	

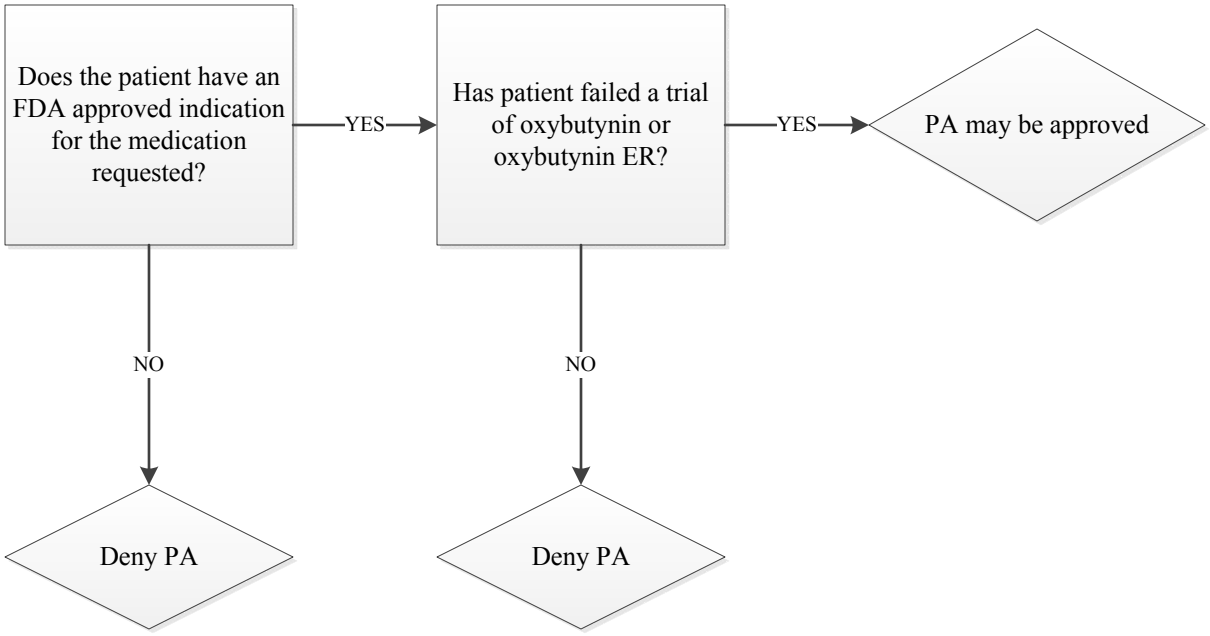
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

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



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

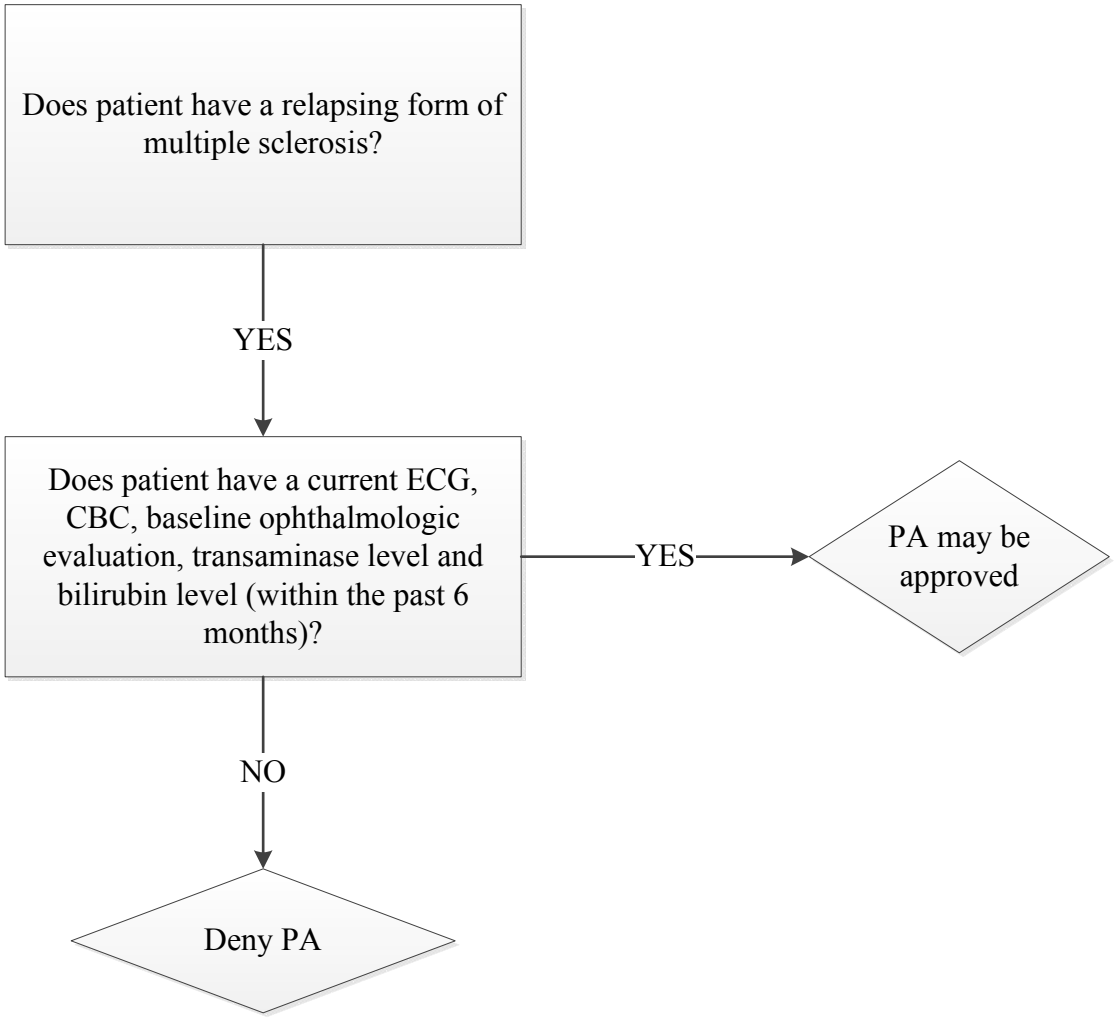
Part II: TO BE COMPLETED BY PHARMACY

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



GRALISE PA FORM

Prior Authorization Vendor for ND Medicaid

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

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

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

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ GRALISE	**Diagnosis for this Request:**		
Failed Therapy (dose and frequency): □ GABAPENTIN	**Start Date:** **End Date:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber Signature		Date	

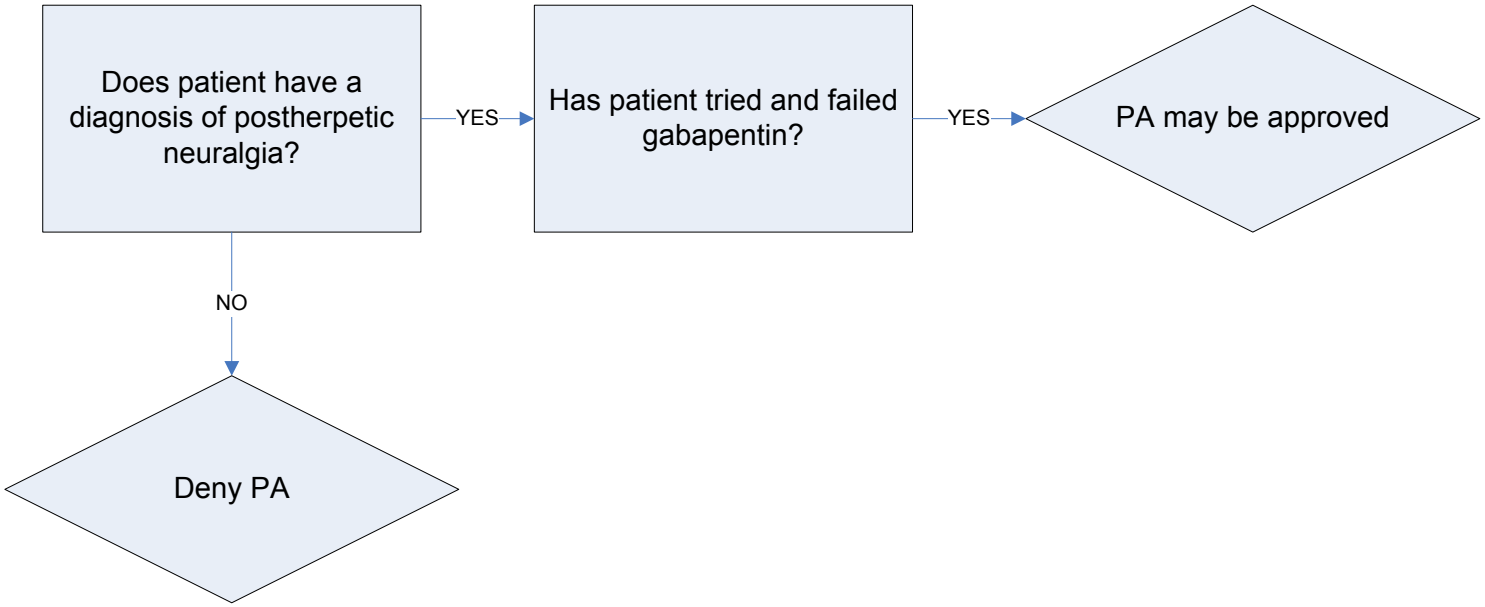
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Gralise Prior Authorization Algorithm



Growth Hormone 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 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:	

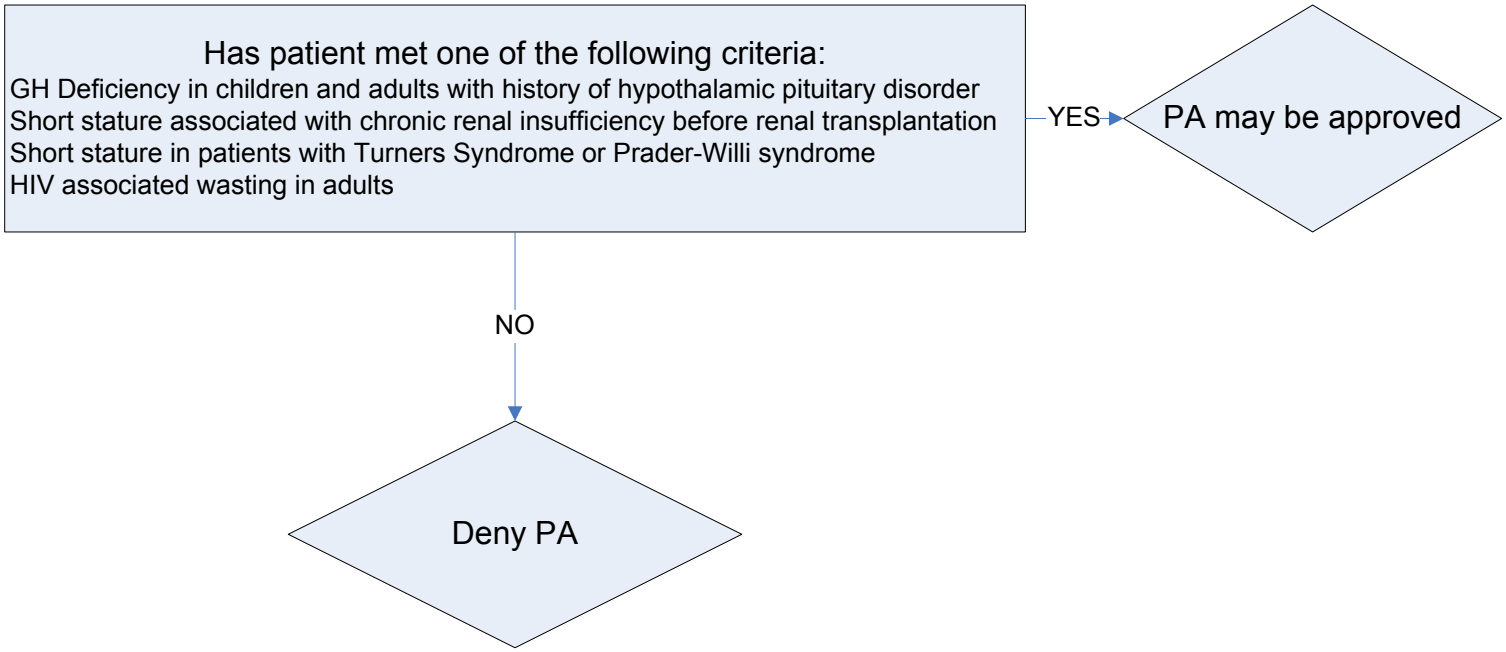
Part II: TO BE COMPLETED BY PHARMACY

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	

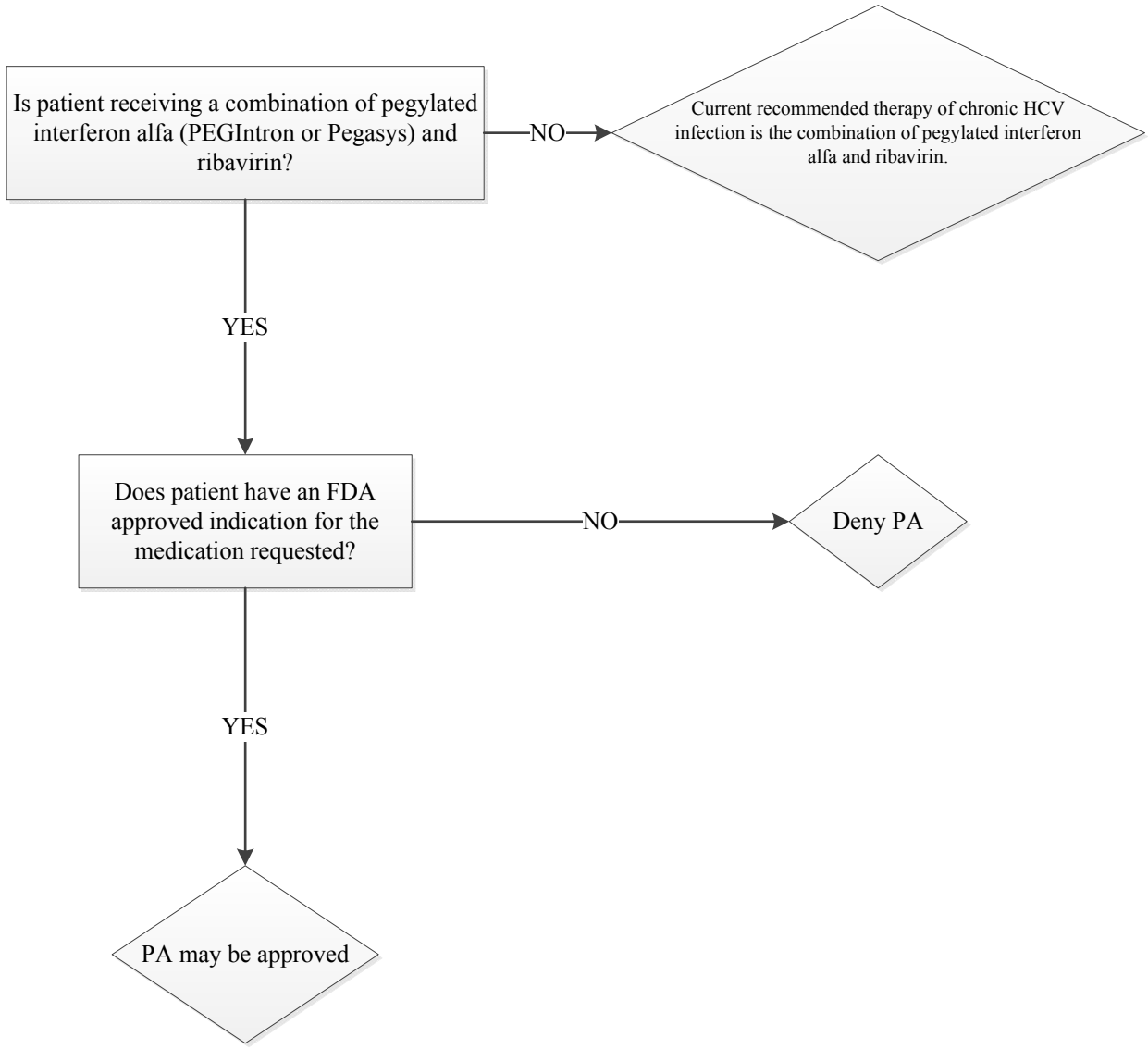
Part II: TO BE COMPLETED BY PHARMACY

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		

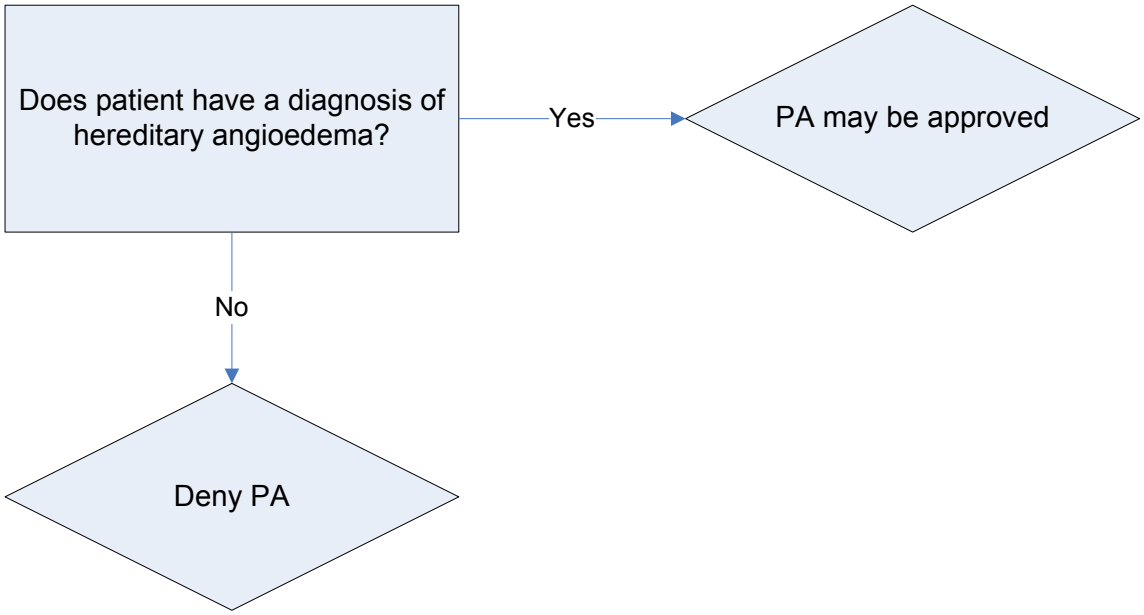
Part II: TO BE COMPLETED BY PHARMACY

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	

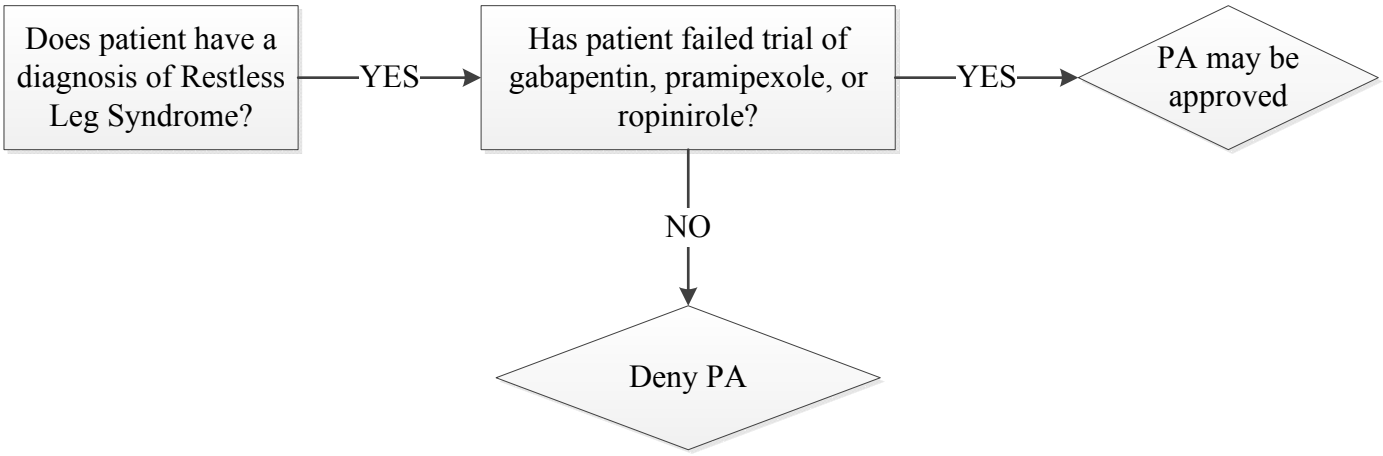
Part II: TO BE COMPLETED BY PHARMACY

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

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 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

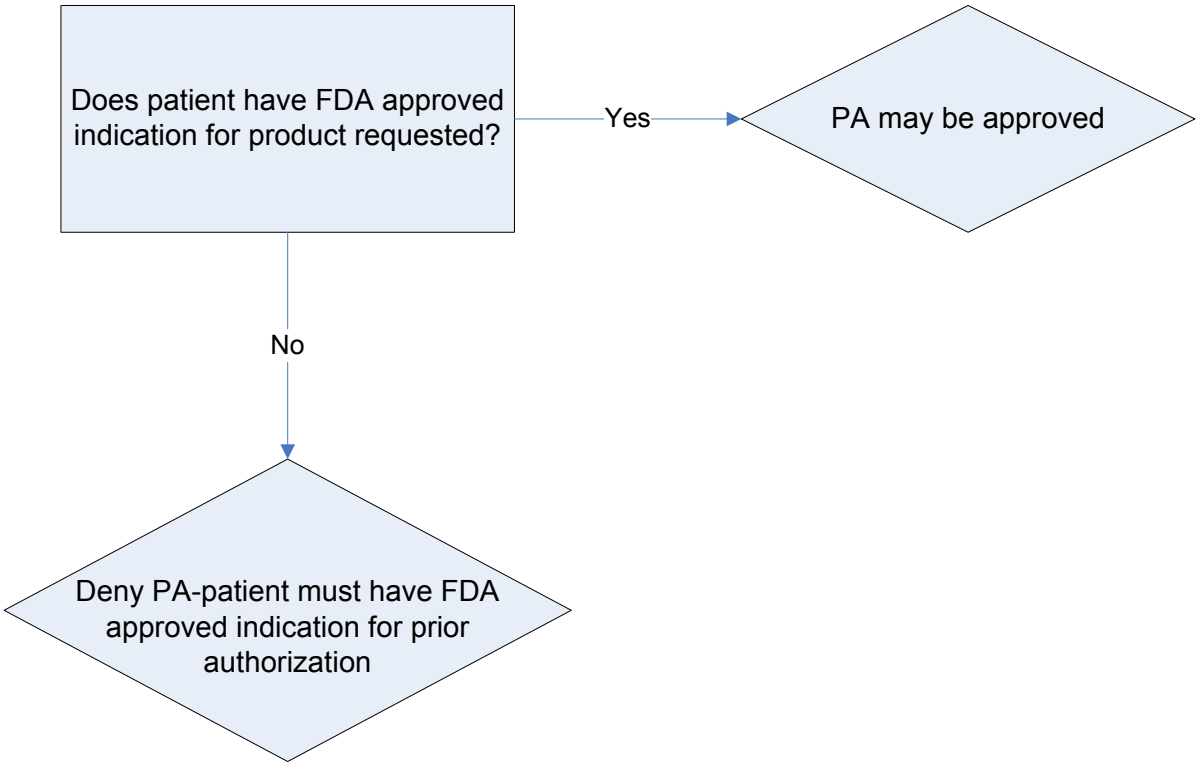
Part II: TO BE COMPLETED BY PHARMACY

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



KALYDECO PA FORM

Prior Authorization Vendor for ND Medicaid

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

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

- **Patient must have a G551D mutation in the cystic fibrosis conductance regulator (CFTR) gene.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ KALYDECO	**Diagnosis for this Request:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber Signature		Date	

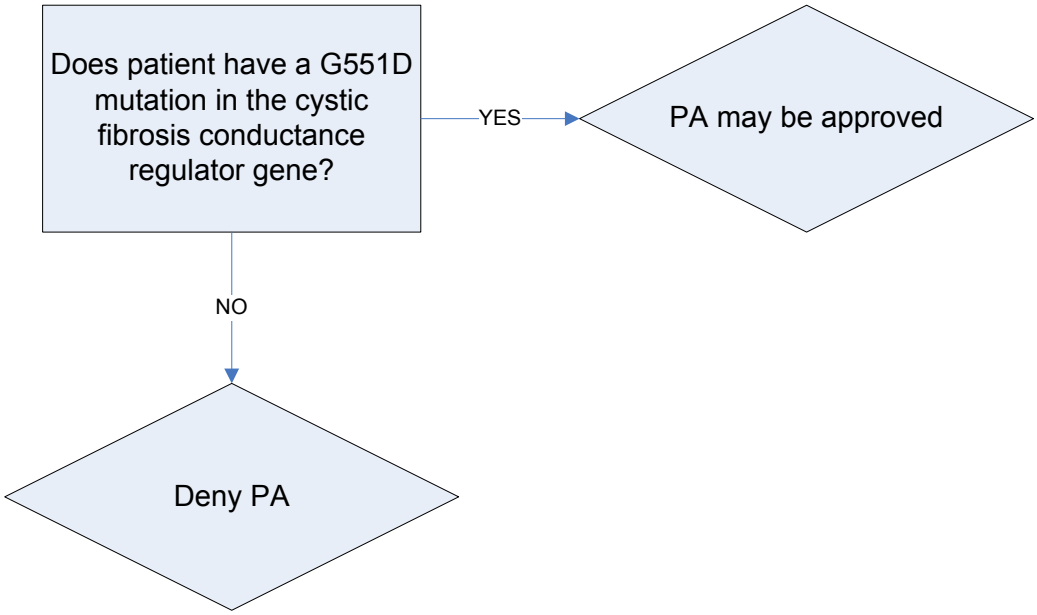
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Kalydeco Prior Authorization Algorithm



KAPVAY 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 Kapvay must meet the following criteria:

- **Patient must first try clonidine**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ KAPVAY	**Diagnosis for this Request:**		
Failed Therapy (dose and frequency): □	**Start Date:** **End Date:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber Signature		Date	

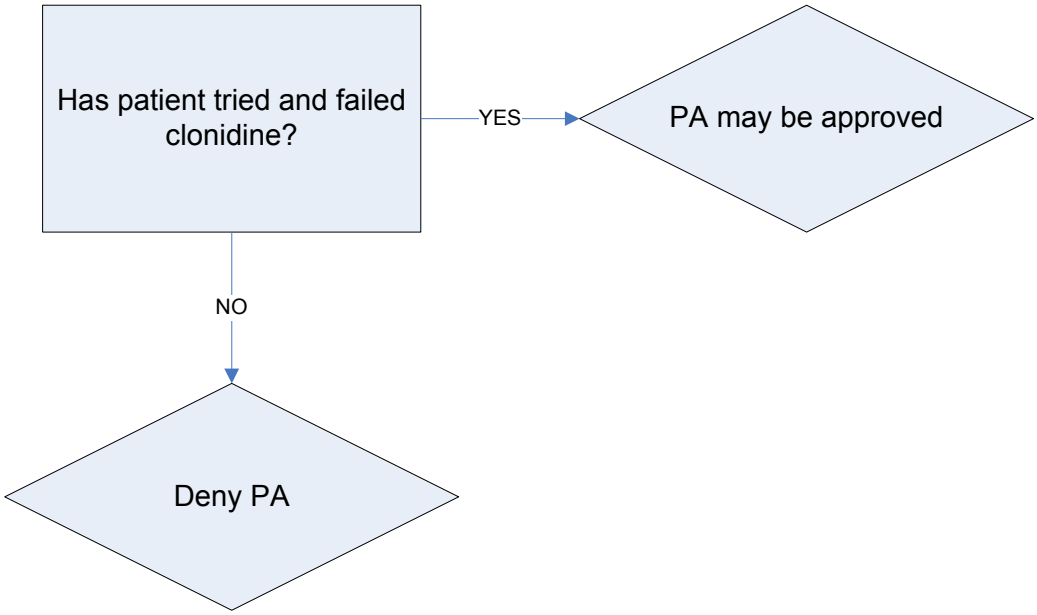
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Kapvay Prior Authorization Algorithm



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:

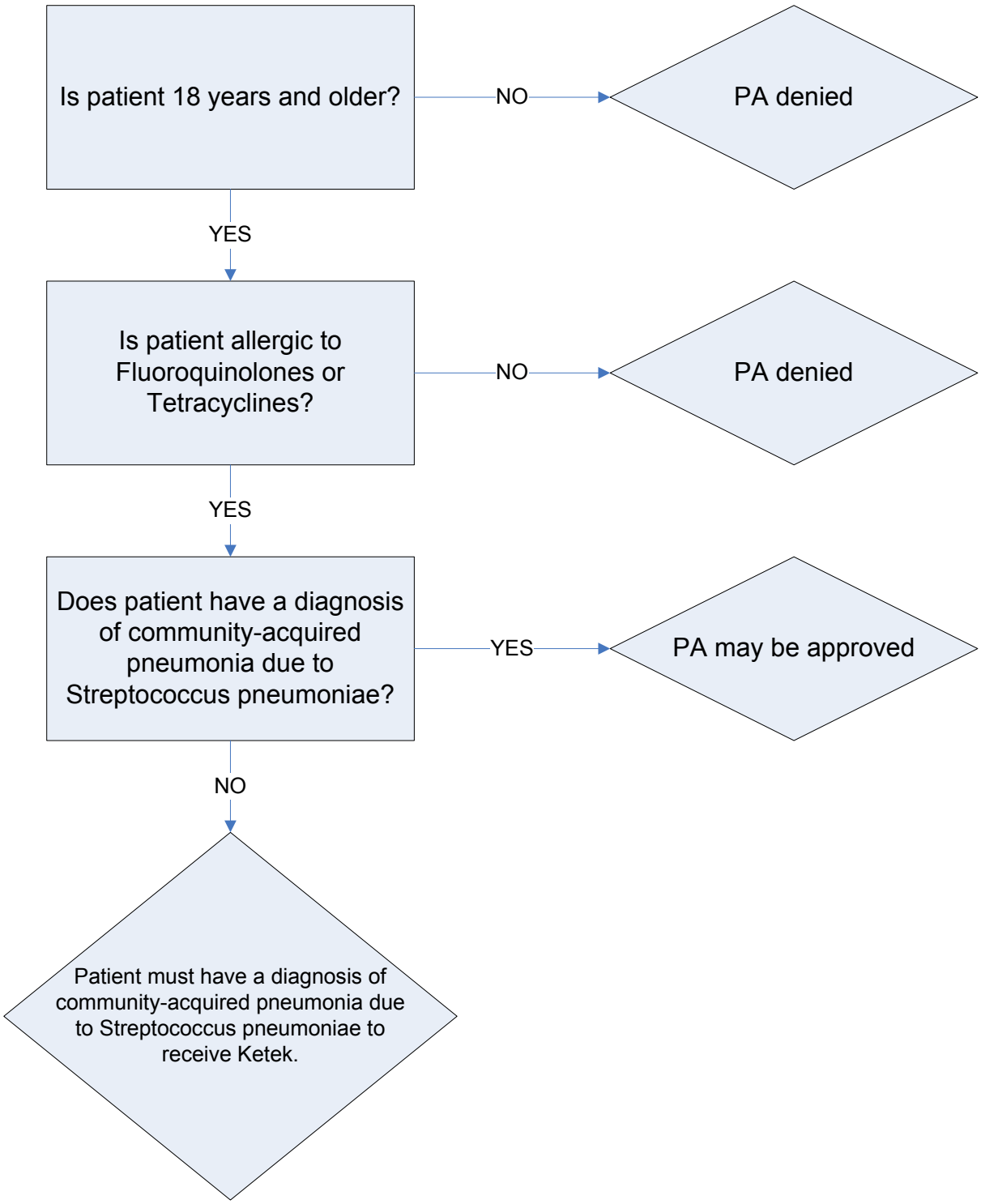
Part II: TO BE COMPLETED BY PHARMACY

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



KUVAN PA FORM

Prior Authorization Vendor for ND Medicaid

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

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

- **Patient must have hyperphenalaninemia.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ KUVAN	**Diagnosis for this Request:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber Signature		Date	

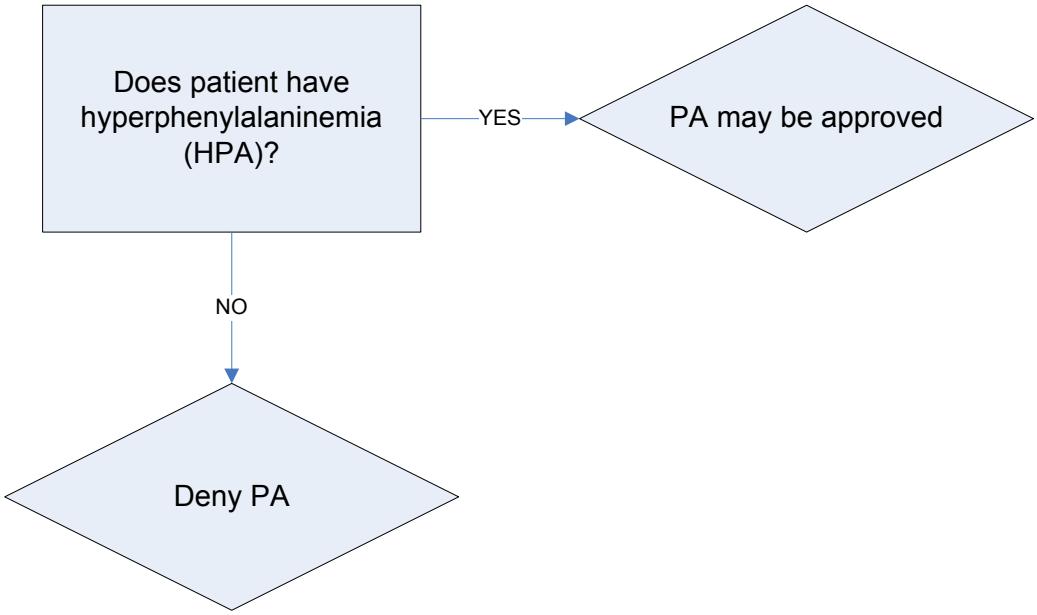
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Kuvan Prior Authorization 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	

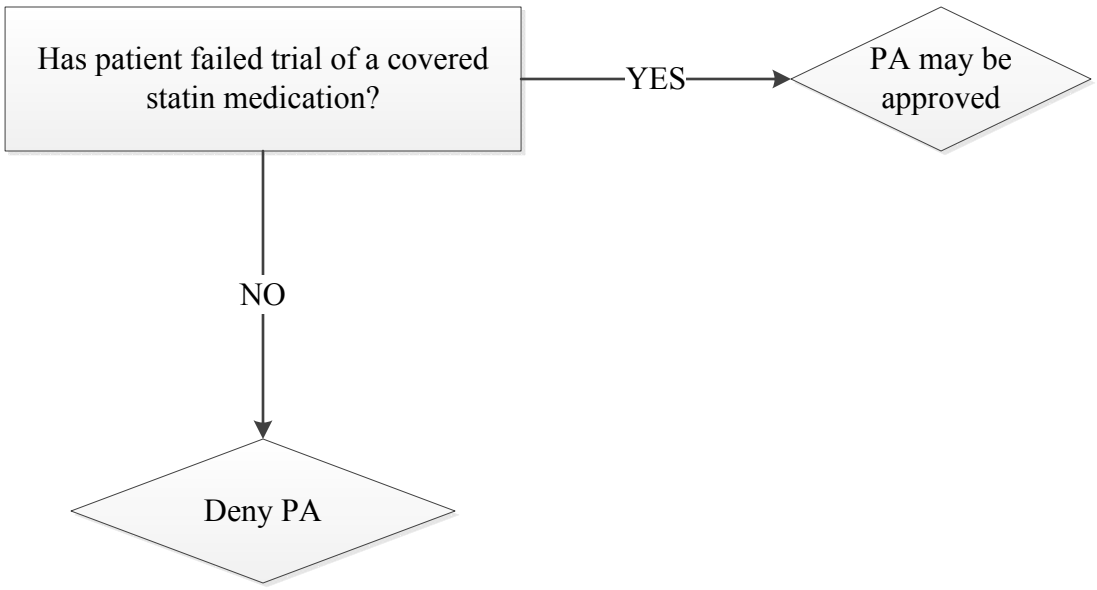
Part II: TO BE COMPLETED BY PHARMACY

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



LORZONE 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 Lorzone must meet the following criteria:

- **Patient must first try chlorzoxazone**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ LORZONE	**Diagnosis for this Request:**		
Failed Therapy (dose and frequency): □ CHLORZOXAZONE	**Start Date:** **End Date:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber Signature		Date	

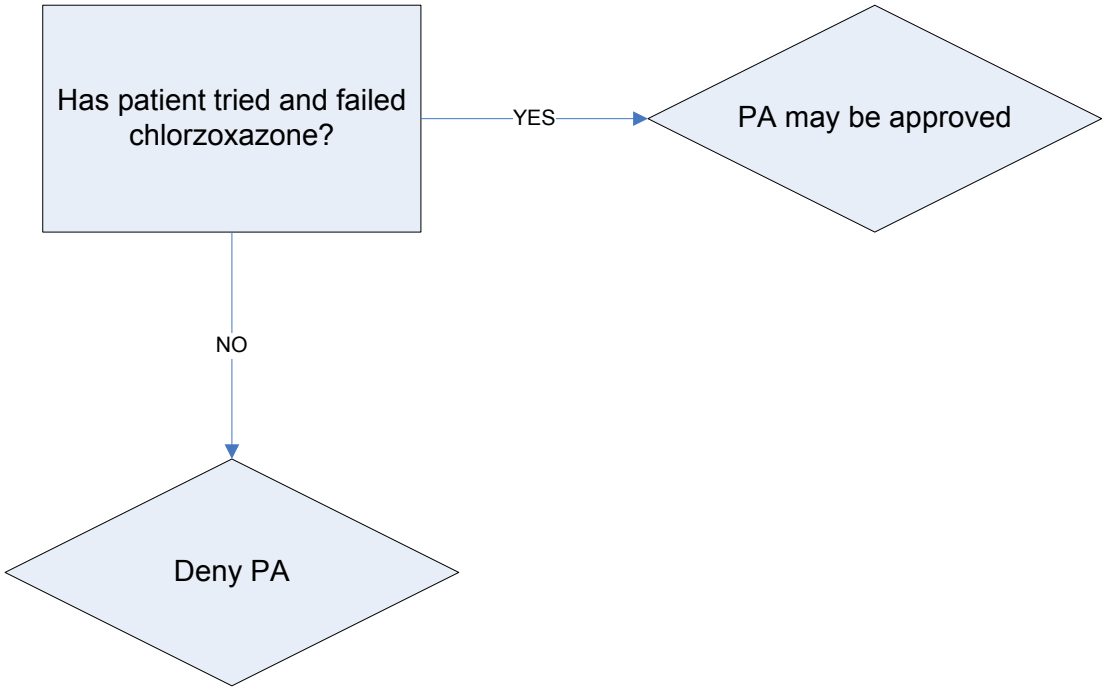
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Lorzone Prior 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	

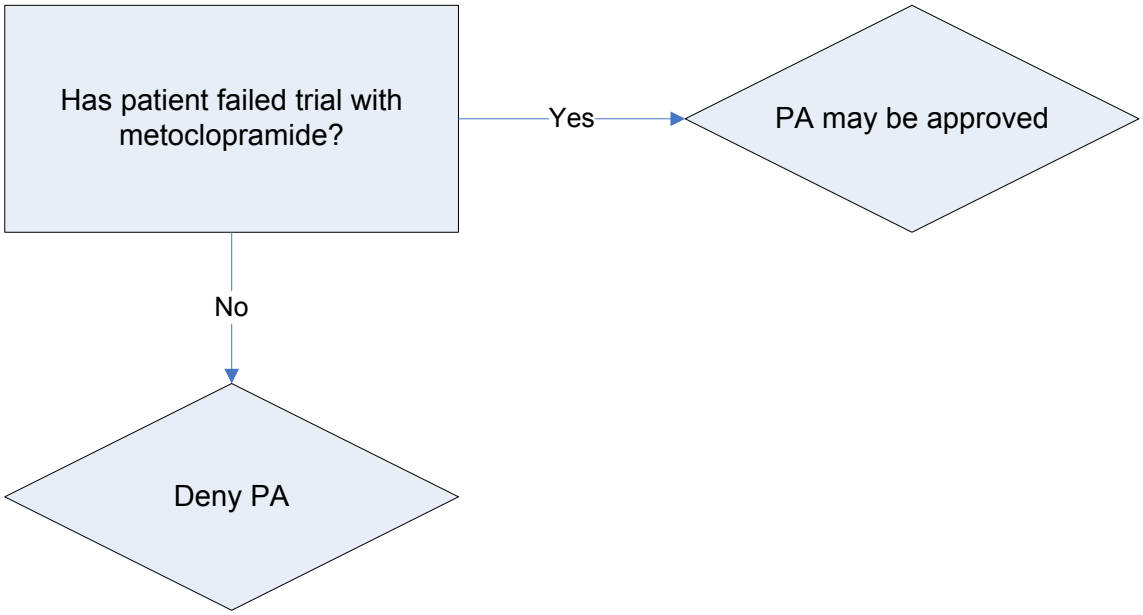
Part II: TO BE COMPLETED BY PHARMACY

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

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 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

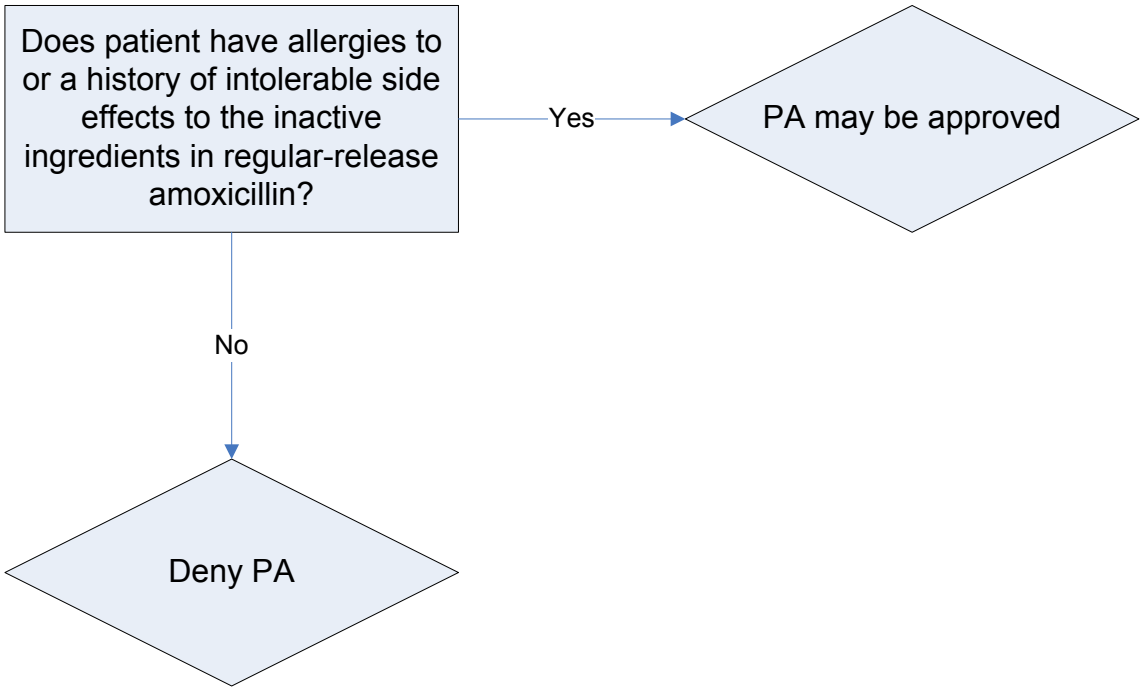
Part II: TO BE COMPLETED BY PHARMACY

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.

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	

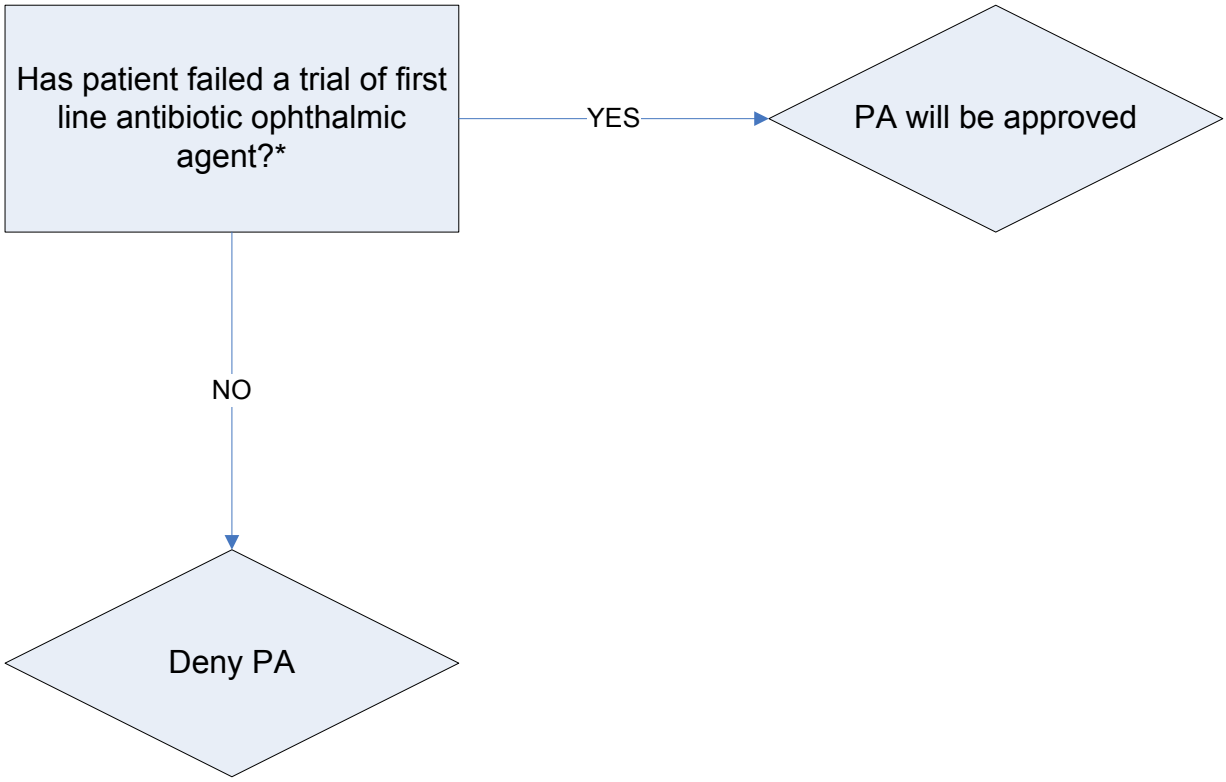
Part II: TO BE COMPLETED BY PHARMACY

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).

BRAND-NAME NARCOTICS PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

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

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

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

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:

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

□ OTHER BRAND NAME PRODUCT _____

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

Physician Signature	Date

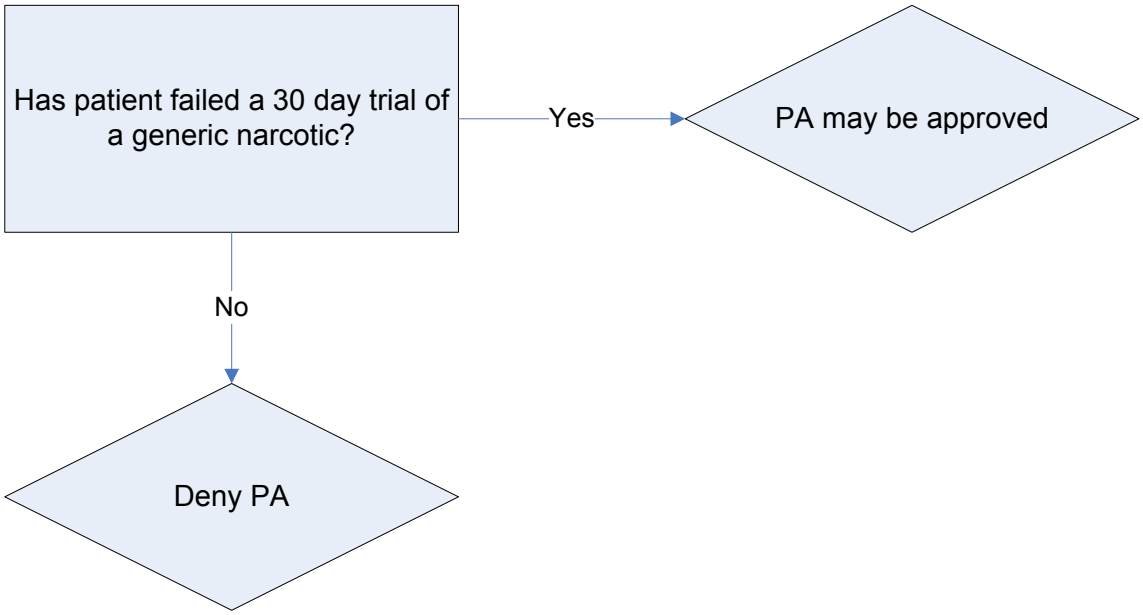
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - 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	

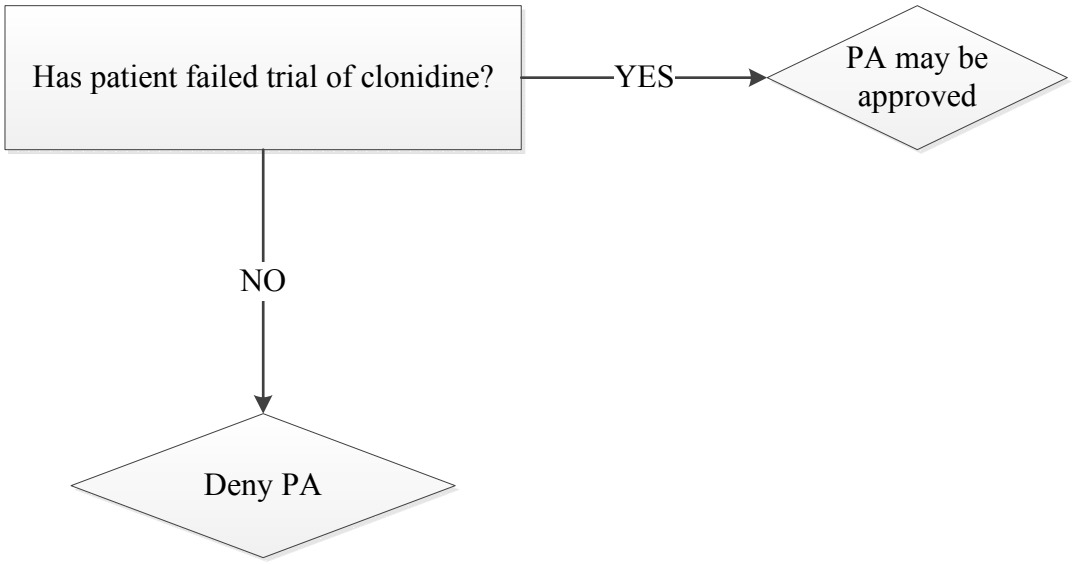
Part II: TO BE COMPLETED BY PHARMACY

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



HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Nucynta 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 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	

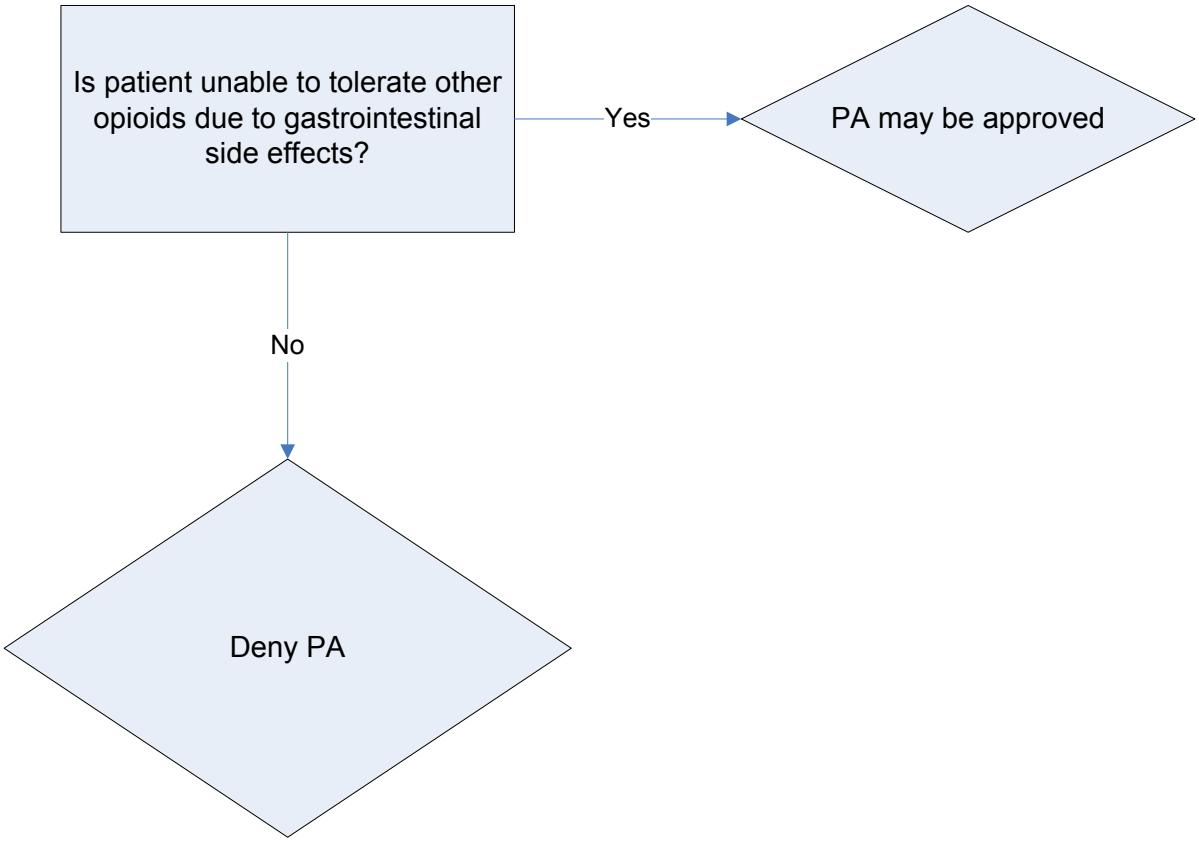
Part II: TO BE COMPLETED BY PHARMACY

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	

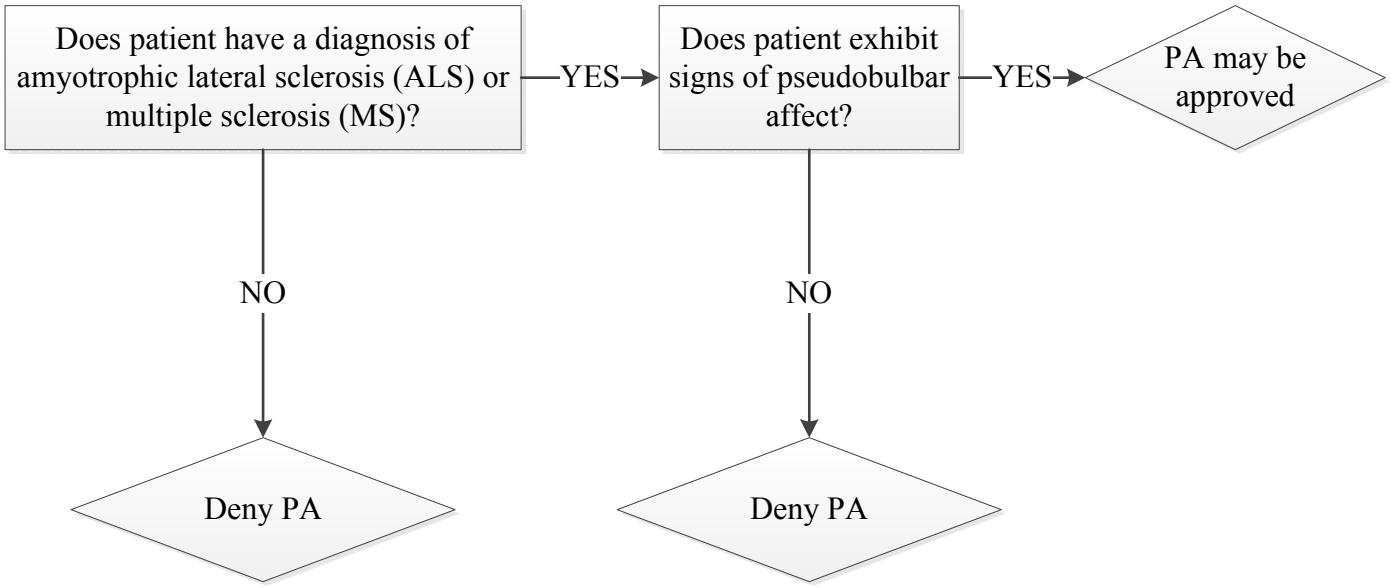
Part II: TO BE COMPLETED BY PHARMACY

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	

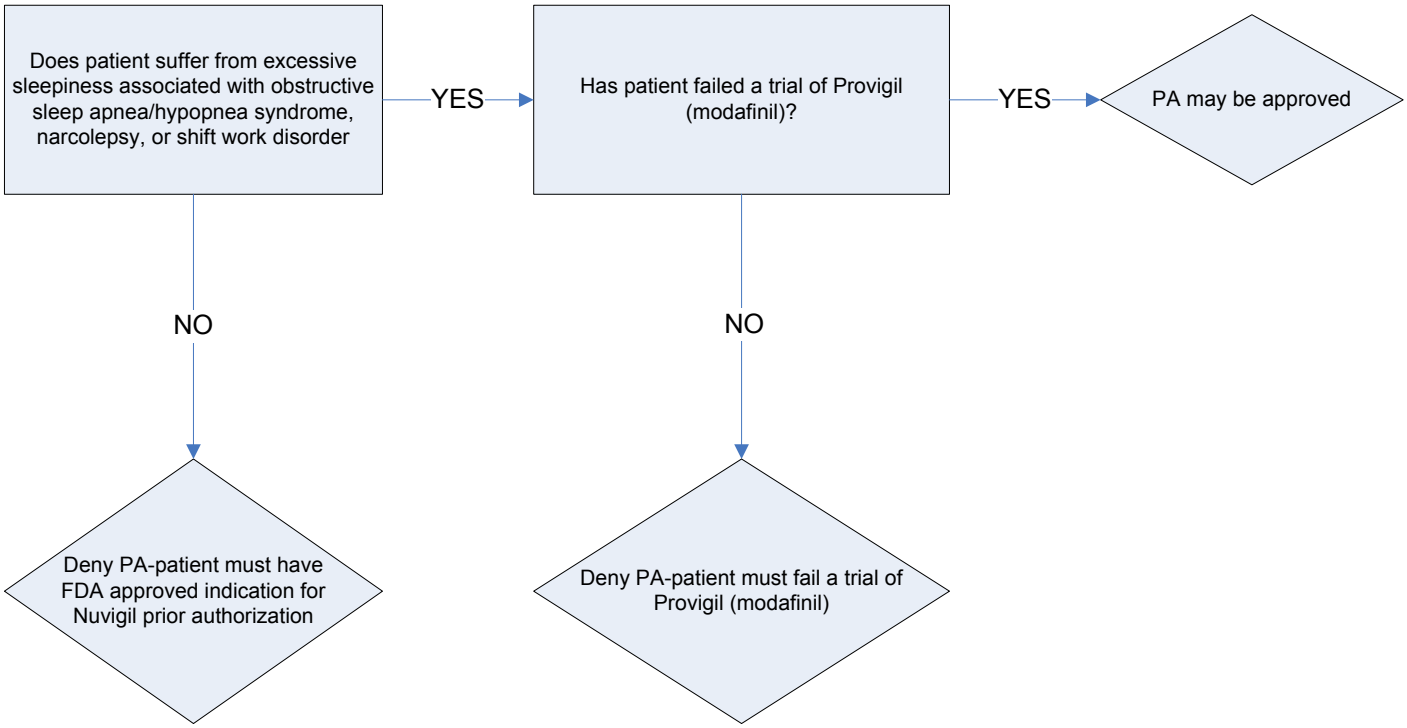
Part II: TO BE COMPLETED BY PHARMACY

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	

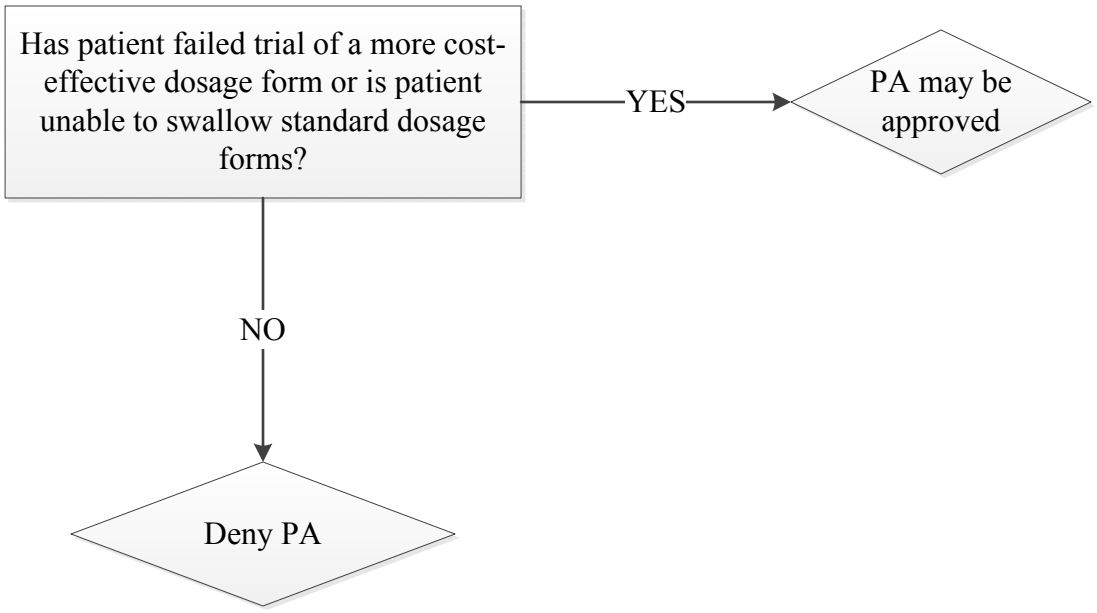
Part II: TO BE COMPLETED BY PHARMACY

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	

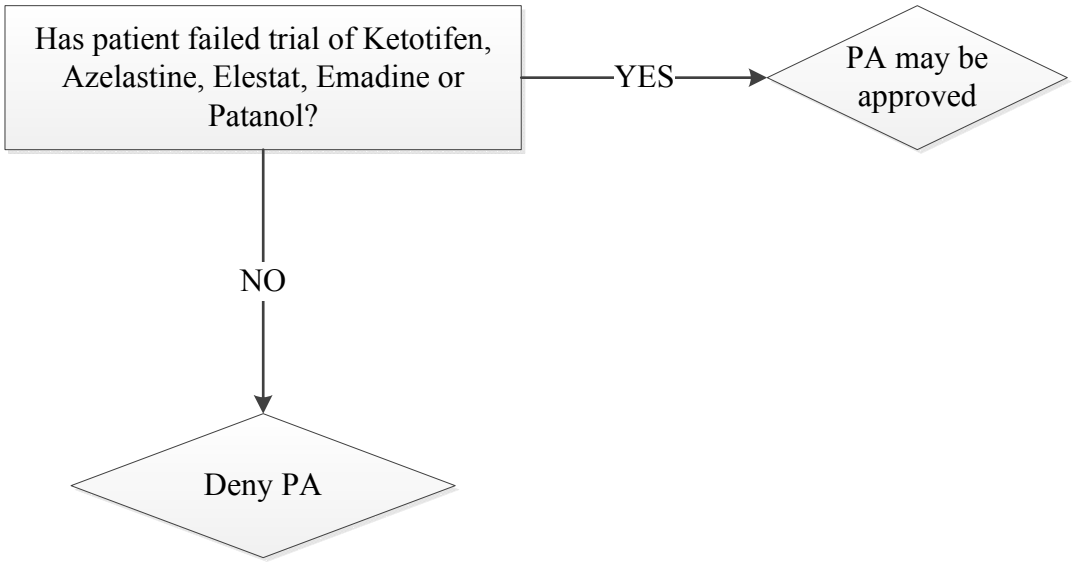
Part II: TO BE COMPLETED BY PHARMACY

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

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

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

ND Medicaid will not pay for Azasite 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		

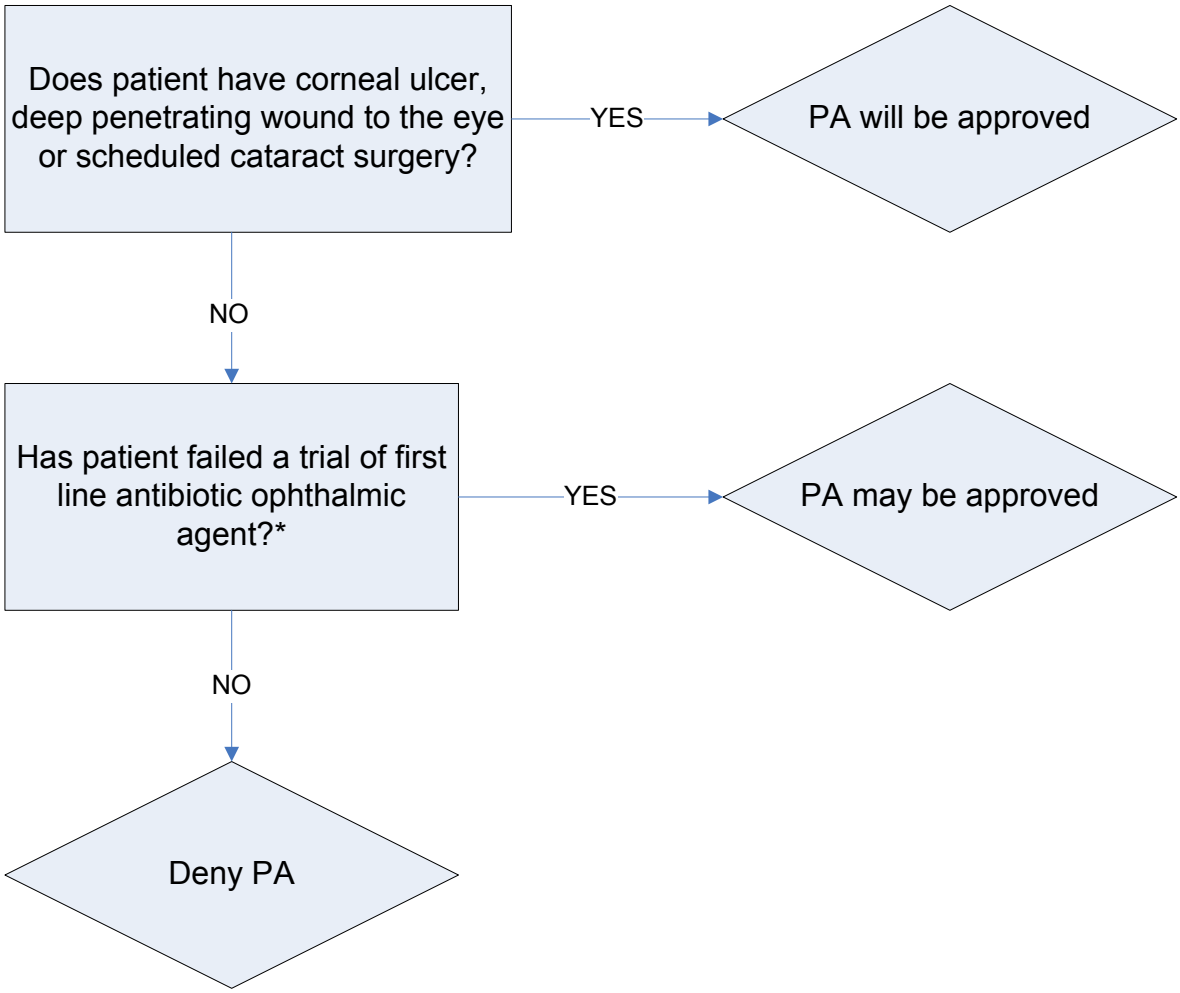
Part II: TO BE COMPLETED BY PHARMACY

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).

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:

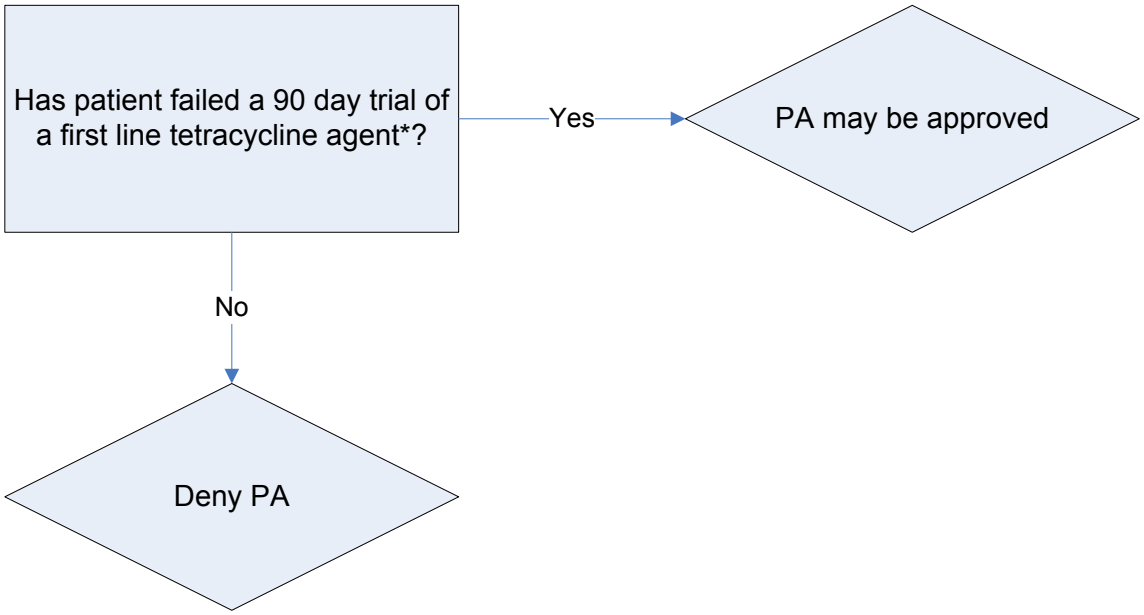
Part II: TO BE COMPLETED BY PHARMACY

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

Prior Authorization Vendor for ND Medicaid

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

ND Medicaid requires that patients receiving a new prescription for Pradaxa, Xarelto or Eliquis must meet the following criteria:

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

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ PRADAXA □ XARELTO □ ELIQUIS	**Diagnosis for this Request:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber Signature	Date		

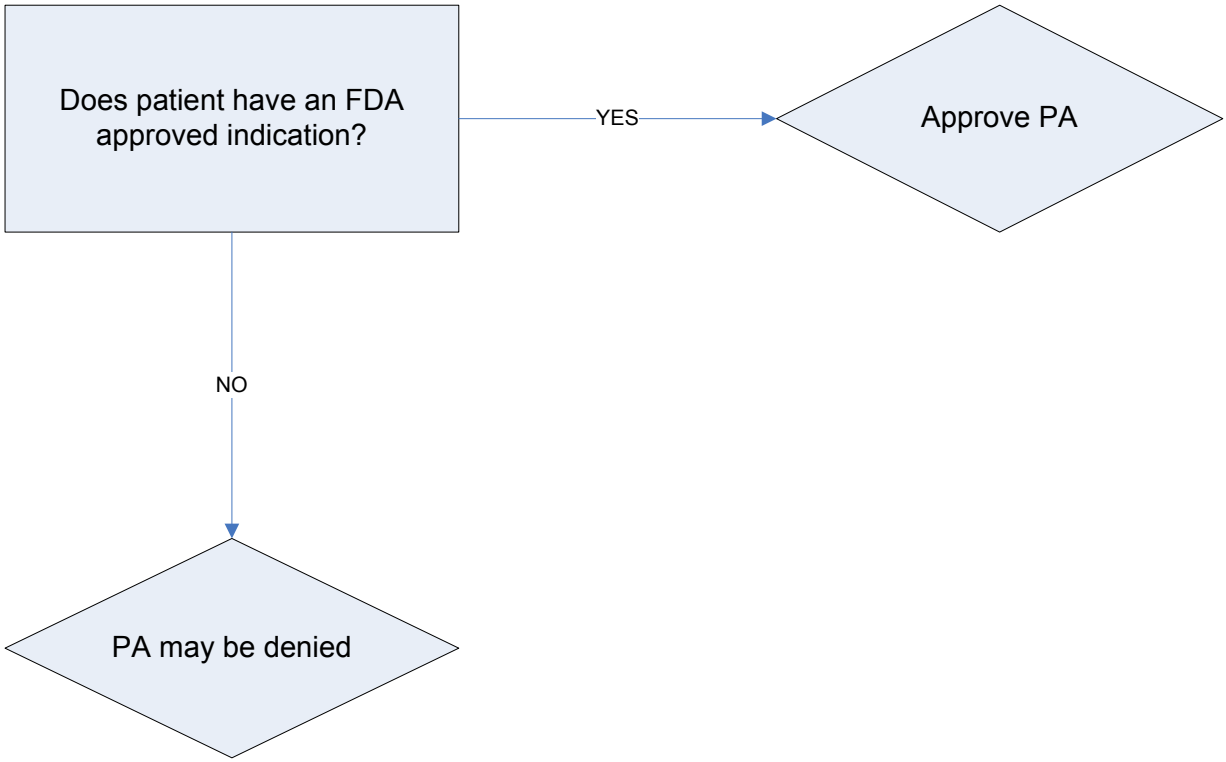
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Oral Anticoagulants Prior Authorization Algorithm



- Pradaxa is indicated to reduce the risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation.
- Xarelto is indicated to reduce the risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation.
- Xarelto is indicated for the treatment of deep vein thrombosis (DVT), pulmonary embolism (PE), and for the reduction in the risk of recurrence of DVT and of PE.
- Xarelto is indicated for the prophylaxis of DVT, which may lead to PE in patients undergoing knee or hip replacement surgery.
- Eliquis is indicated to reduce the risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation.

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	

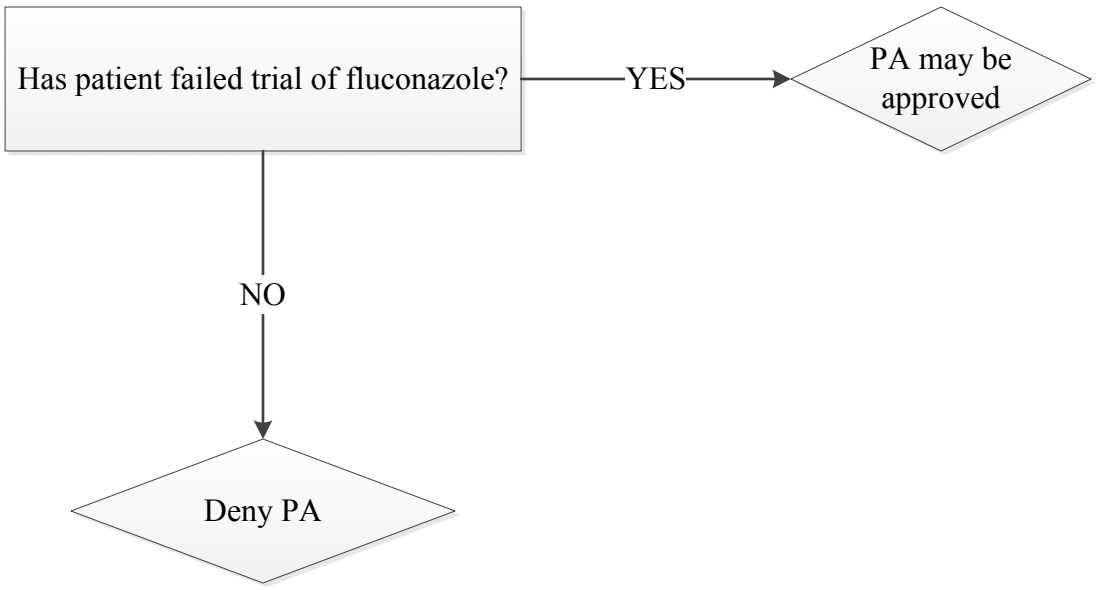
Part II: TO BE COMPLETED BY PHARMACY

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

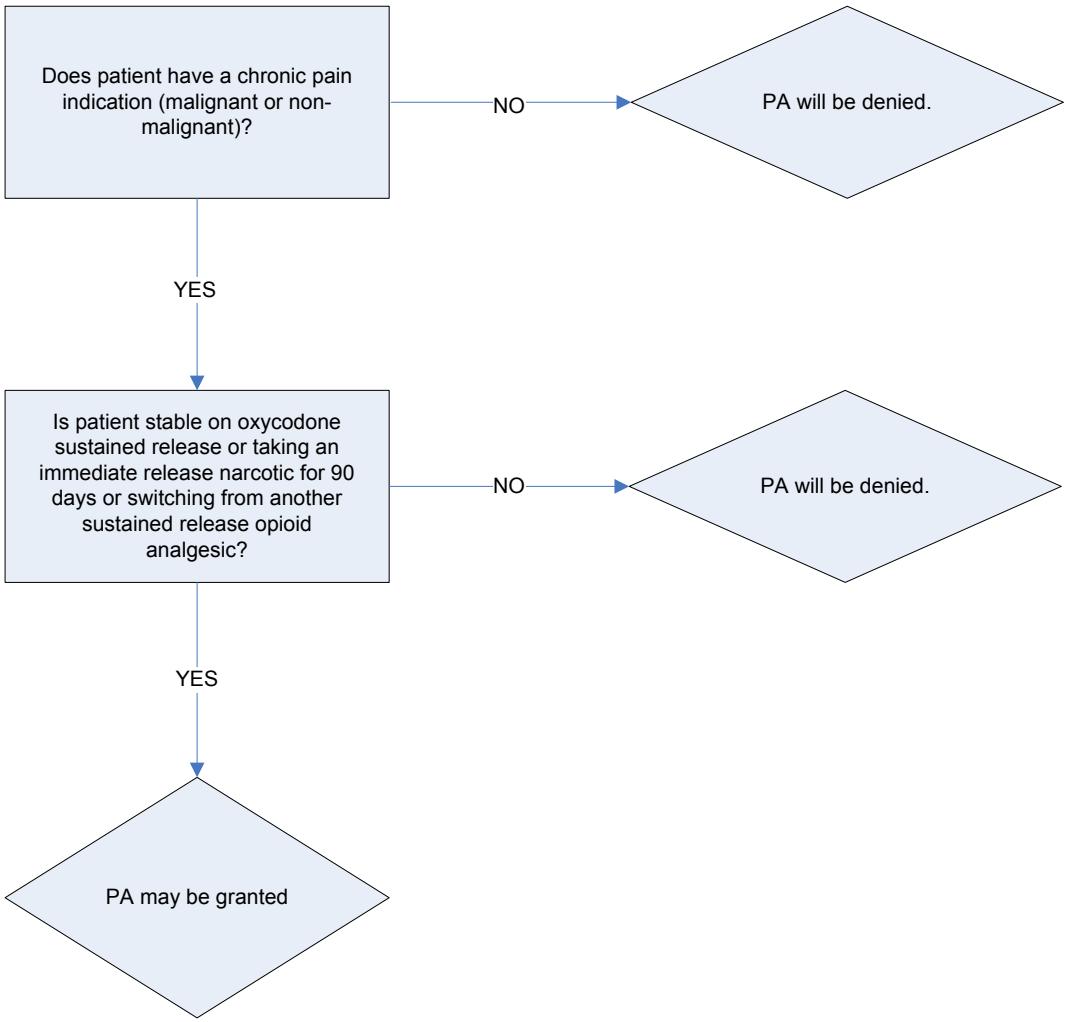
PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

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



HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Proton Pump Inhibitor PA Form

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

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

__Note:__

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

Part I: TO BE COMPLETED BY PRESCRIBER

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

REQUESTED DRUG: □ 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:

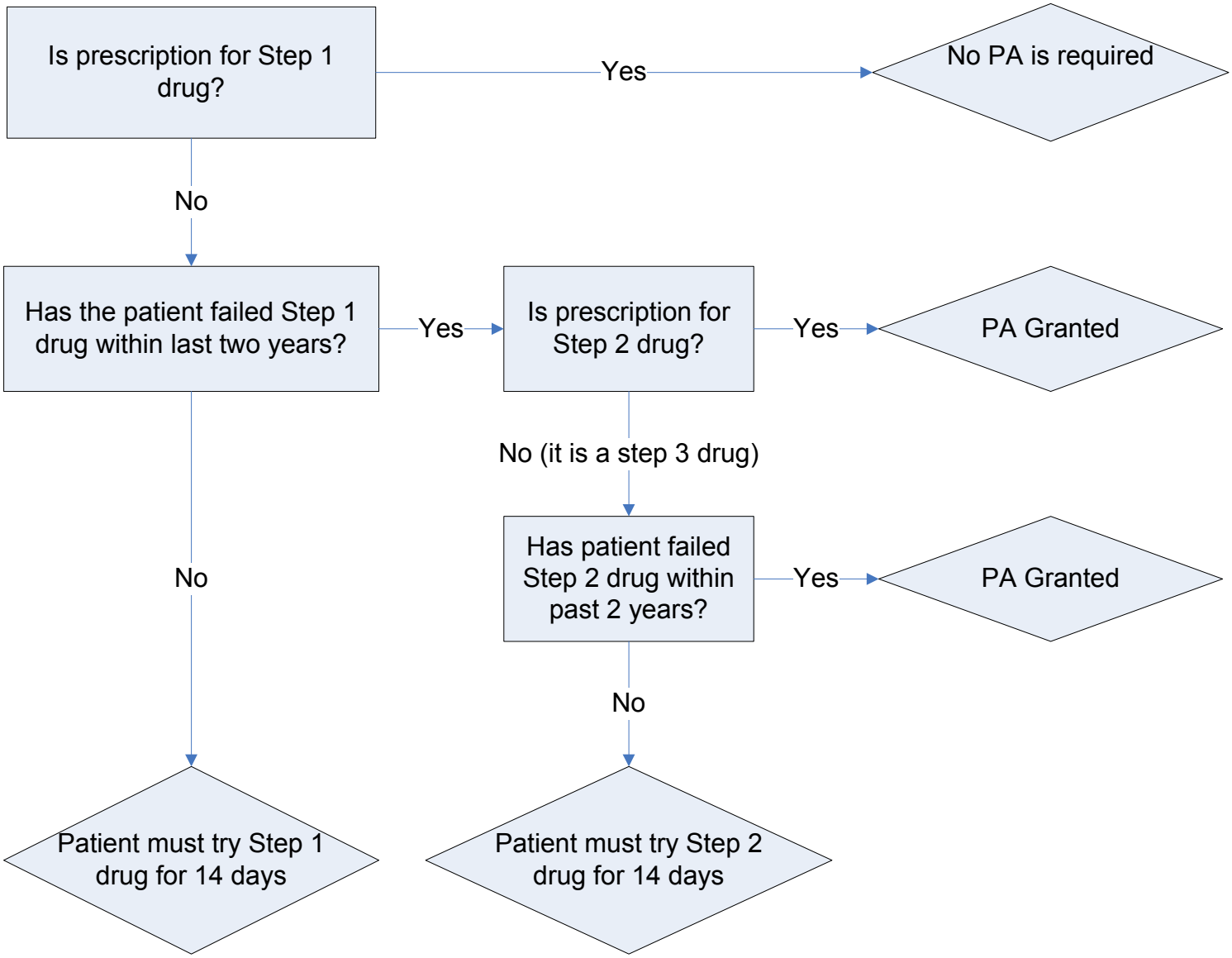
Part II: TO BE COMPLETED BY PHARMACY

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)

PULMONARY ARTERIAL HYPERTENSION AGENTS
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 an agent used to treat pulmonary arterial hypertension (PAH) must meet the following criteria:

- **Patient must have diagnosis of PAH confirmed by a specialist**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name	Specialist Involved in therapy:		
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ LETAIRIS □ TRACLEER □ VENTAVIS □ REVATIO □ ADCIRCA □ TYVASO □ OTHER_____	**Diagnosis for this Request:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber Signature		Date	

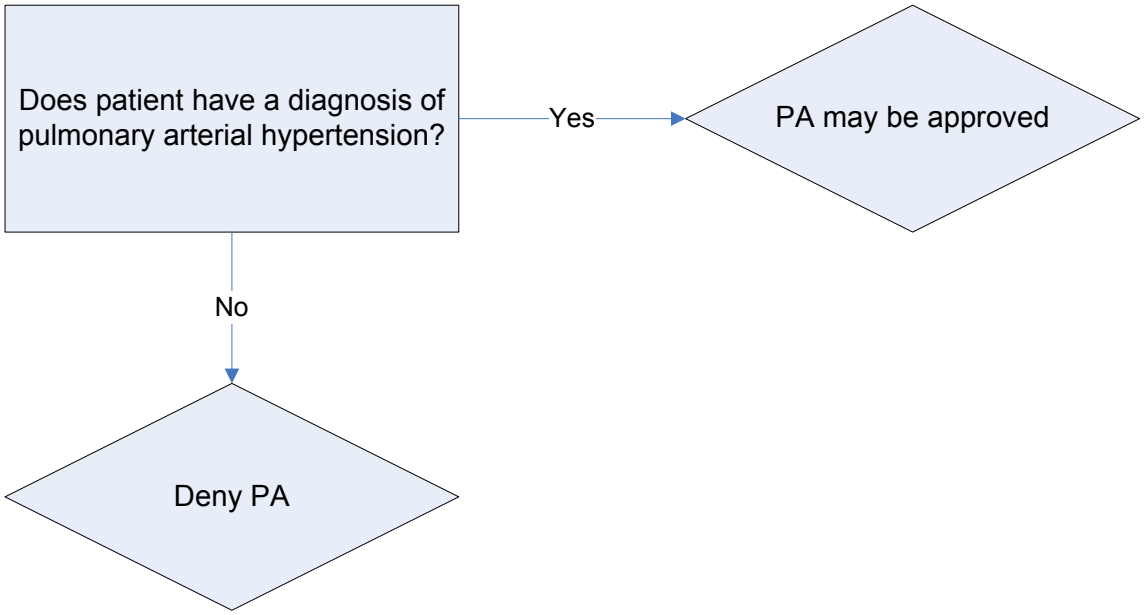
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Pulmonary Arterial Hypertension Agents
Prior Authorization Algorithm



PROVIGIL 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 Provigil must meet the following criteria:

- **Patient must suffer from excessive sleepiness associated with narcolepsy, obstructive sleep apnea, or shift work disorder.**

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: □ PROVIGIL	**Diagnosis for this Request:**		
QUALIFICATIONS FOR COVERAGE: □ Narcolepsy - Sleep study must be attached □ Obstructive Sleep Apnea - Sleep study must be attached □ Shift Work Sleep Disorder – Current shift schedule must be attached			
□ *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	

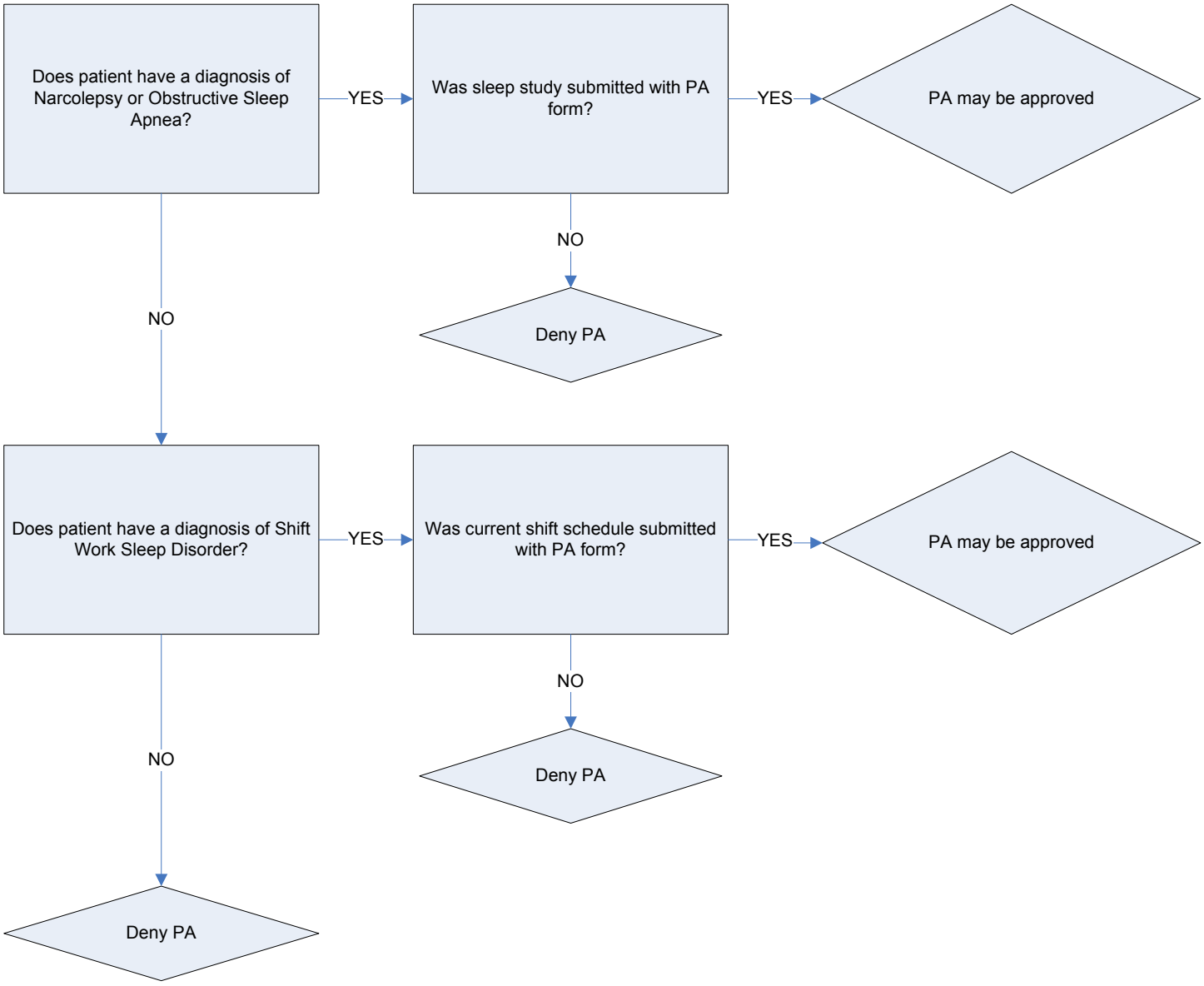
Part II: TO BE COMPLETED BY PHARMACY

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
Provigil Prior Authorization Algorithm



HEALTH INFORMATION DESIGNS

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:

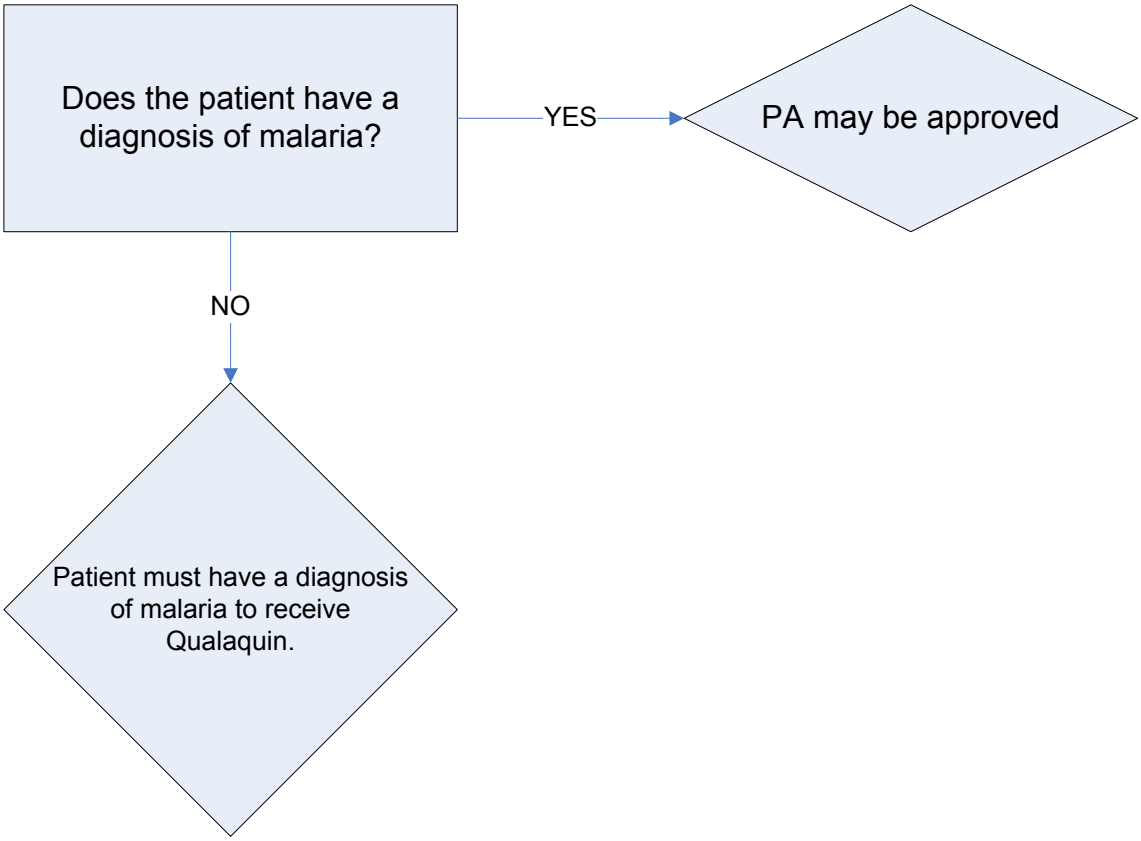
Part II: TO BE COMPLETED BY PHARMACY

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



RIBAPAK PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

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

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

- **Patient must first try Ribavirin or Ribasphere.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ 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

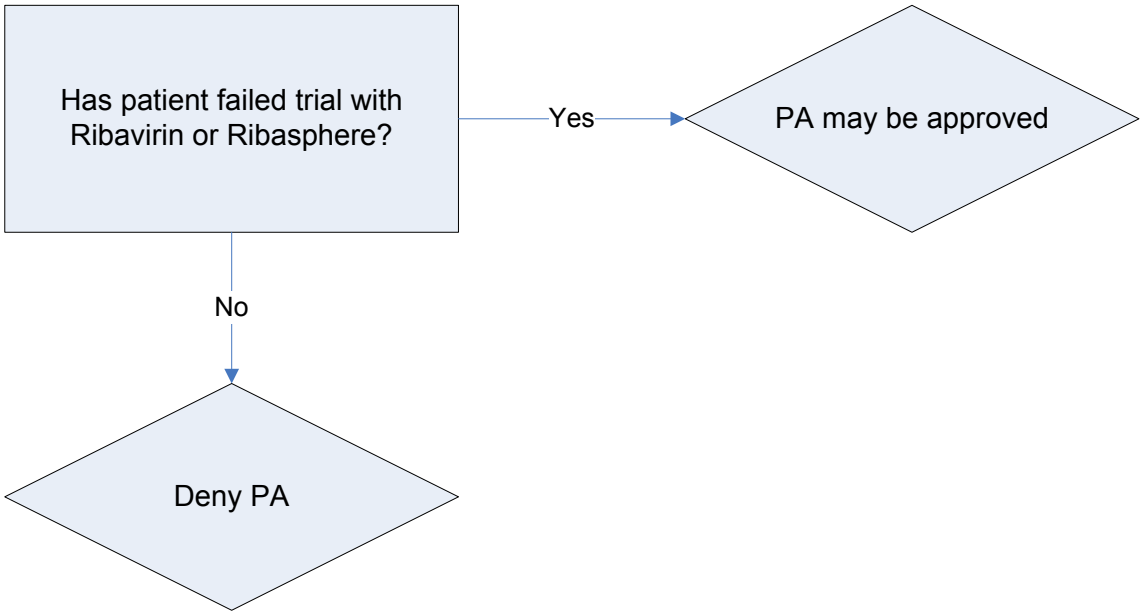
Part II: TO BE COMPLETED BY PHARMACY

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



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	

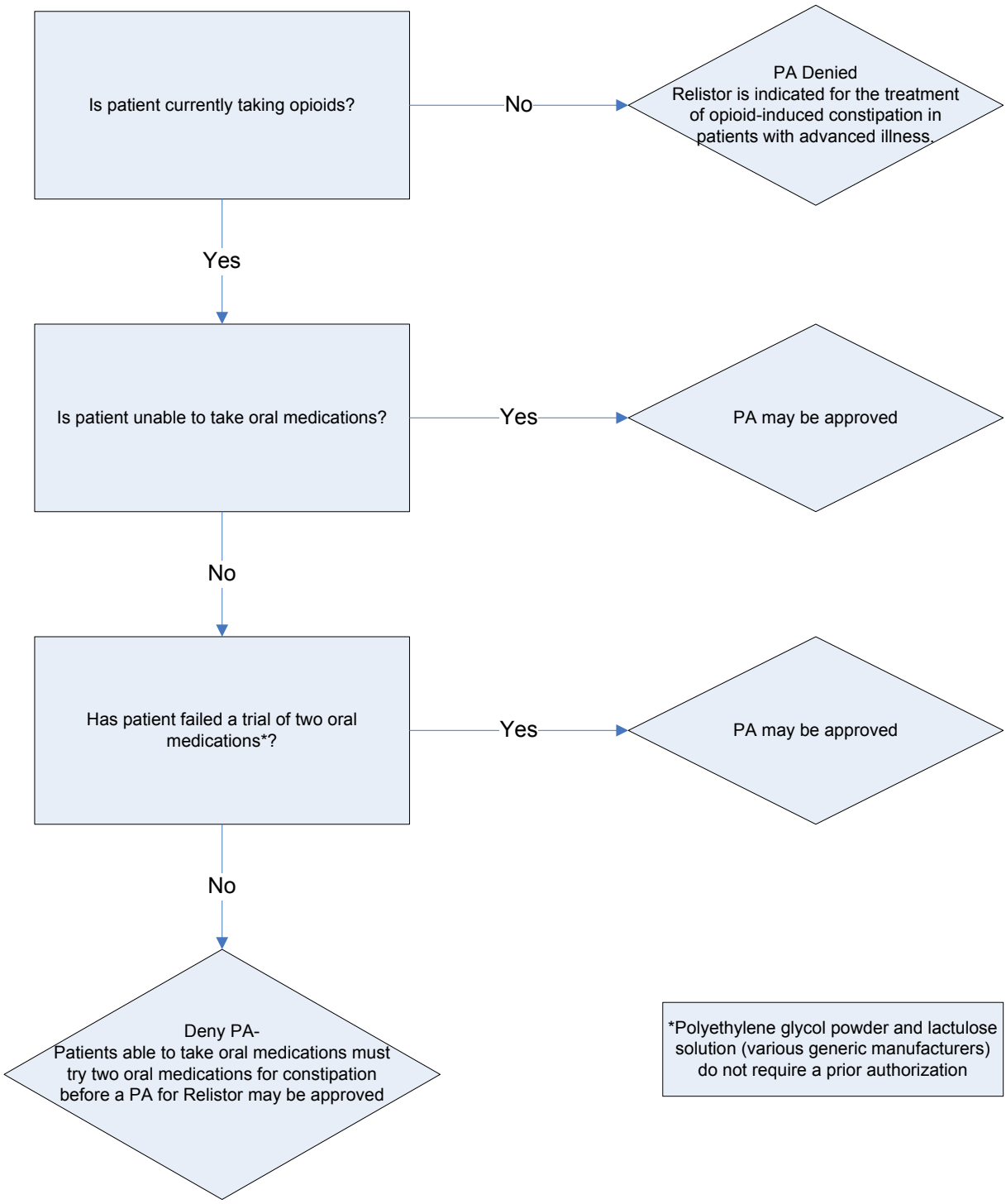
Part II: TO BE COMPLETED BY PHARMACY

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	

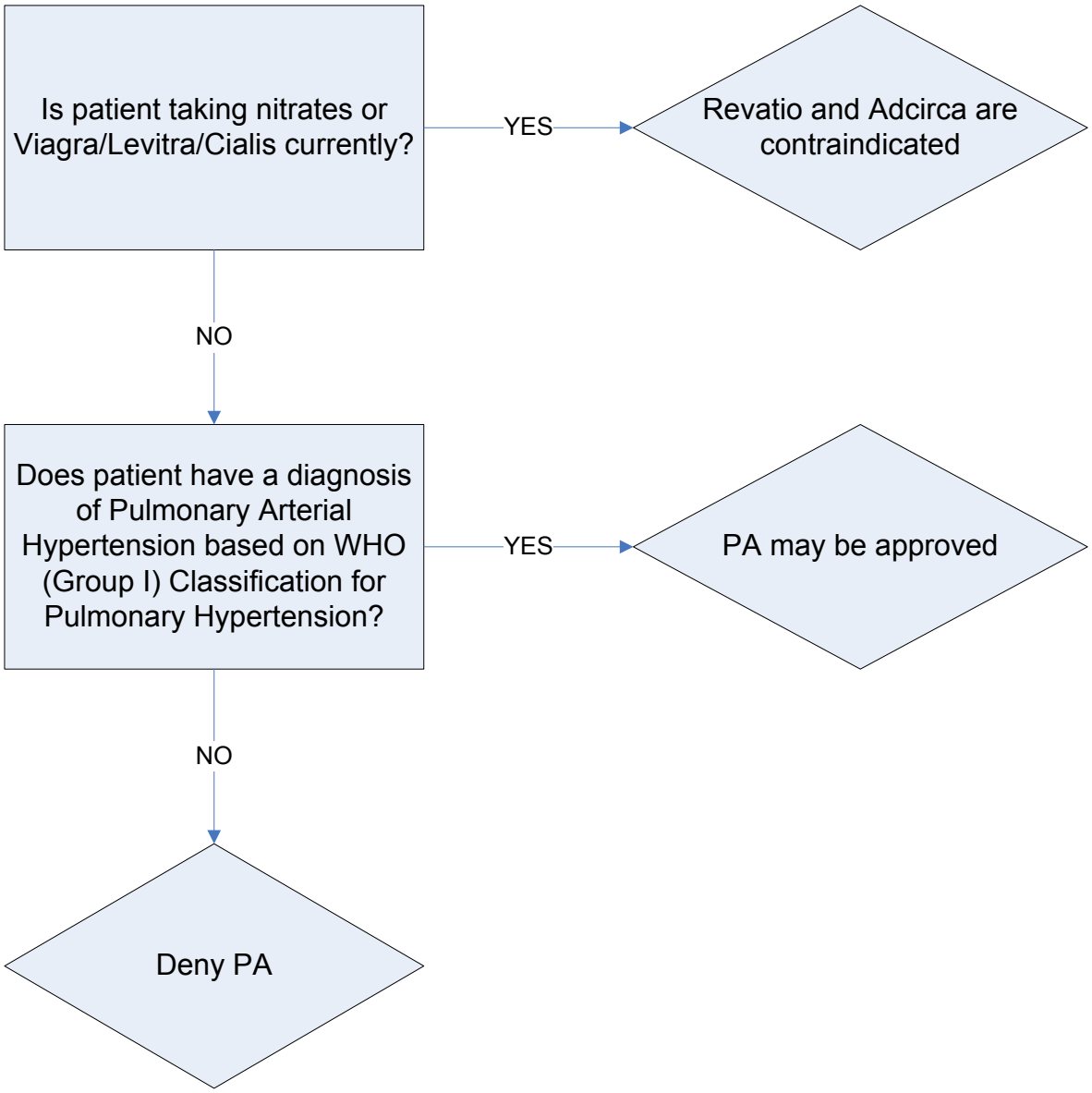
Part II: TO BE COMPLETED BY PHARMACY

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



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	

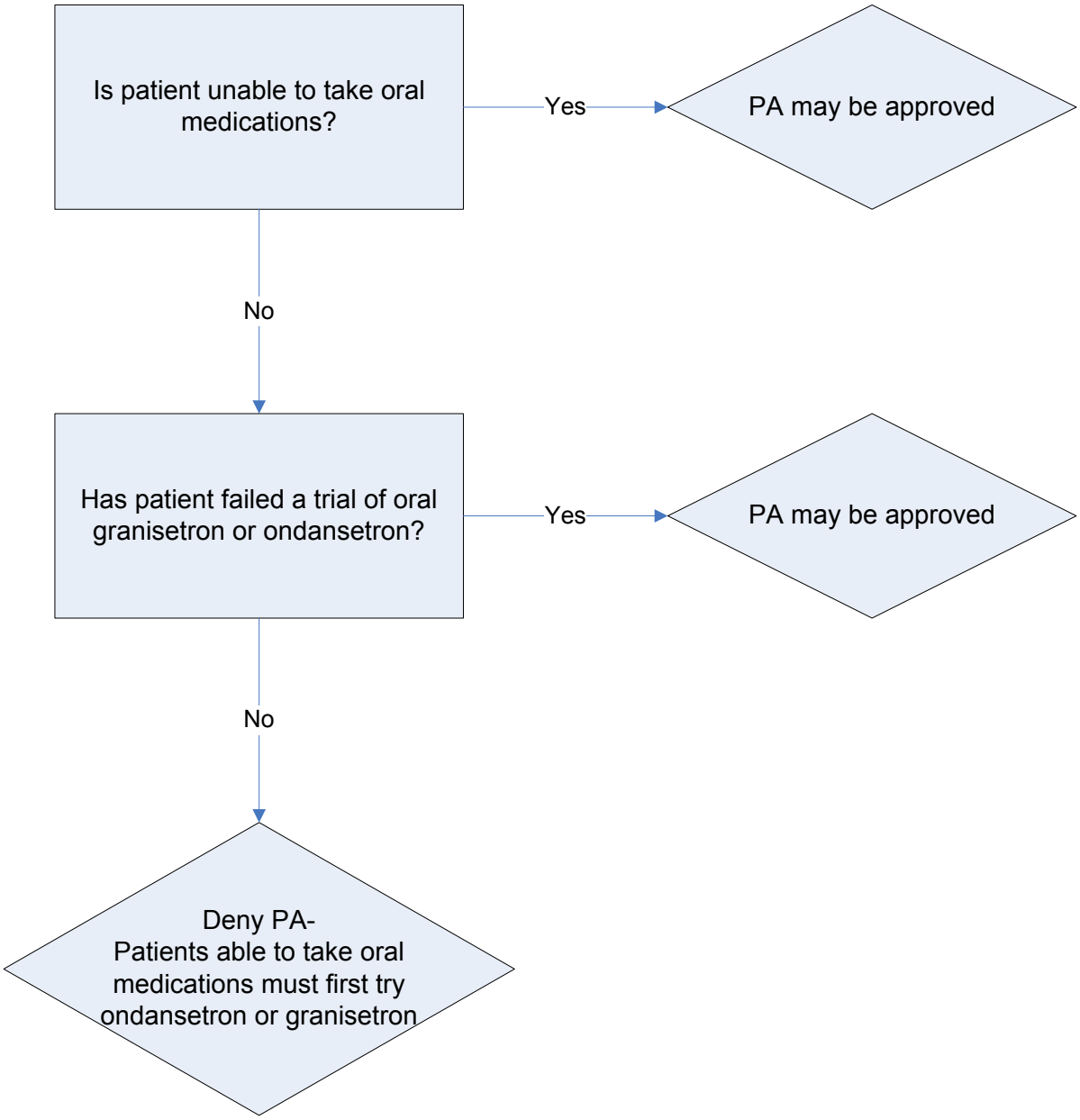
Part II: TO BE COMPLETED BY PHARMACY

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	

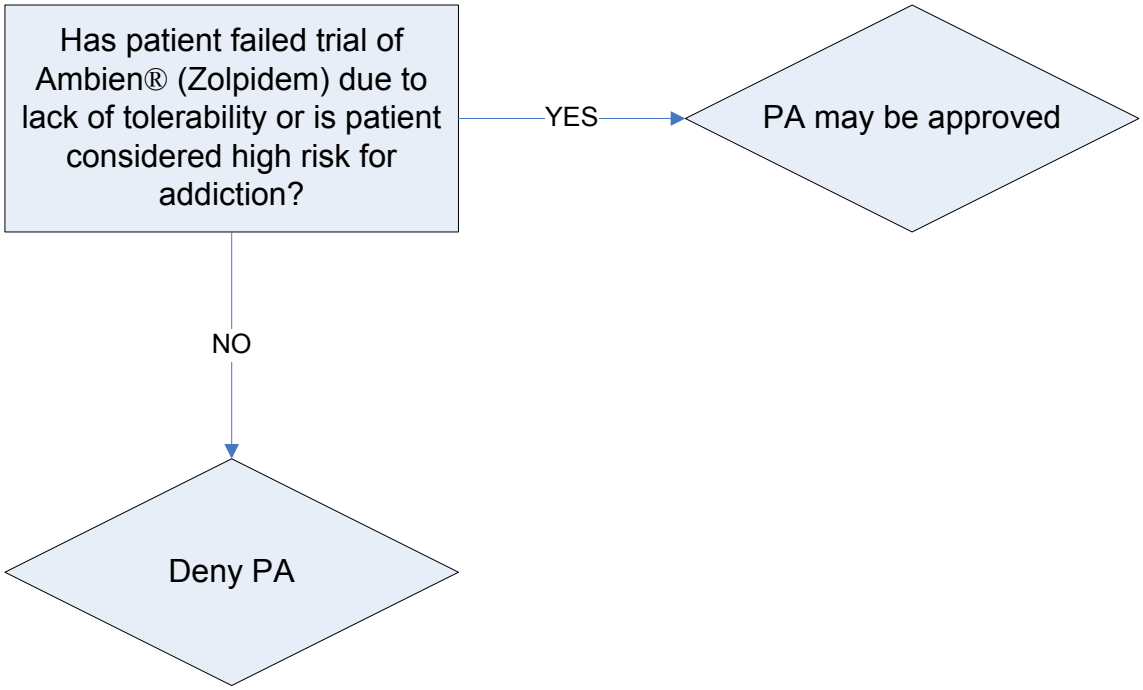
Part II: TO BE COMPLETED BY PHARMACY

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

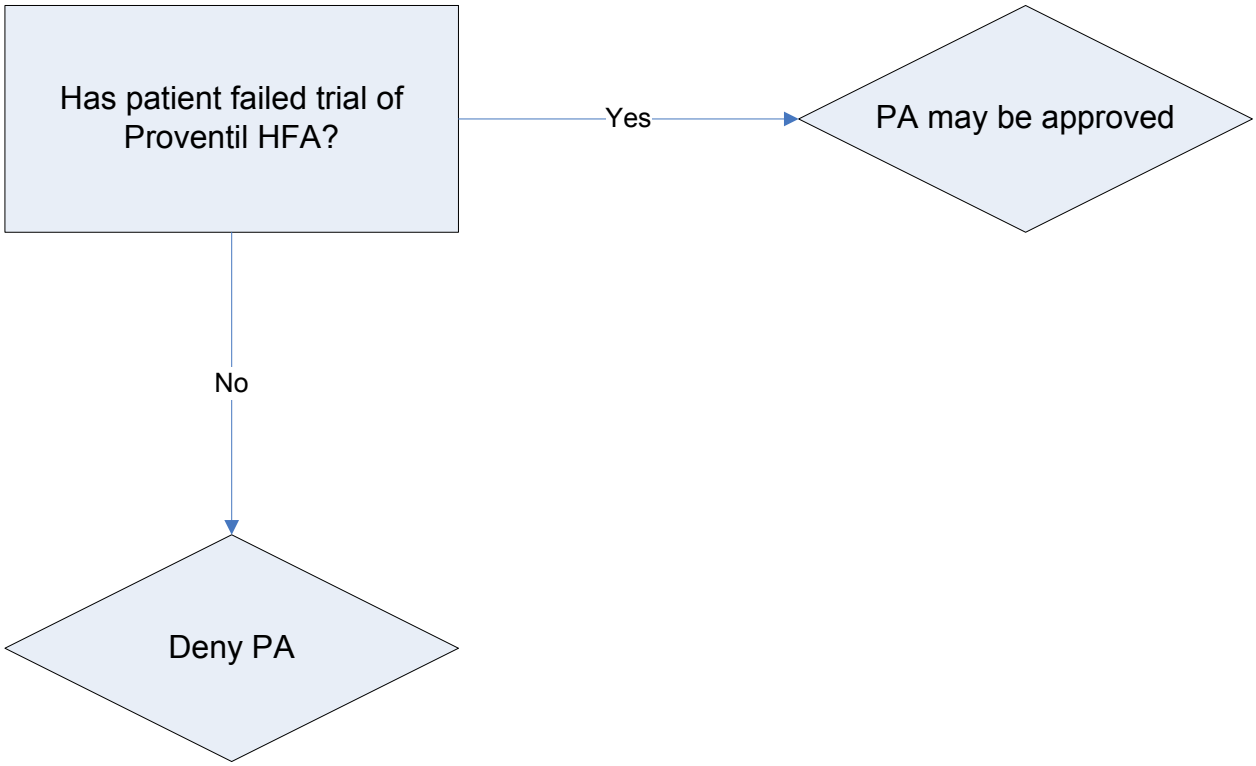
Part II: TO BE COMPLETED BY PHARMACY

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



HEALTH INFORMATION DESIGNS

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:

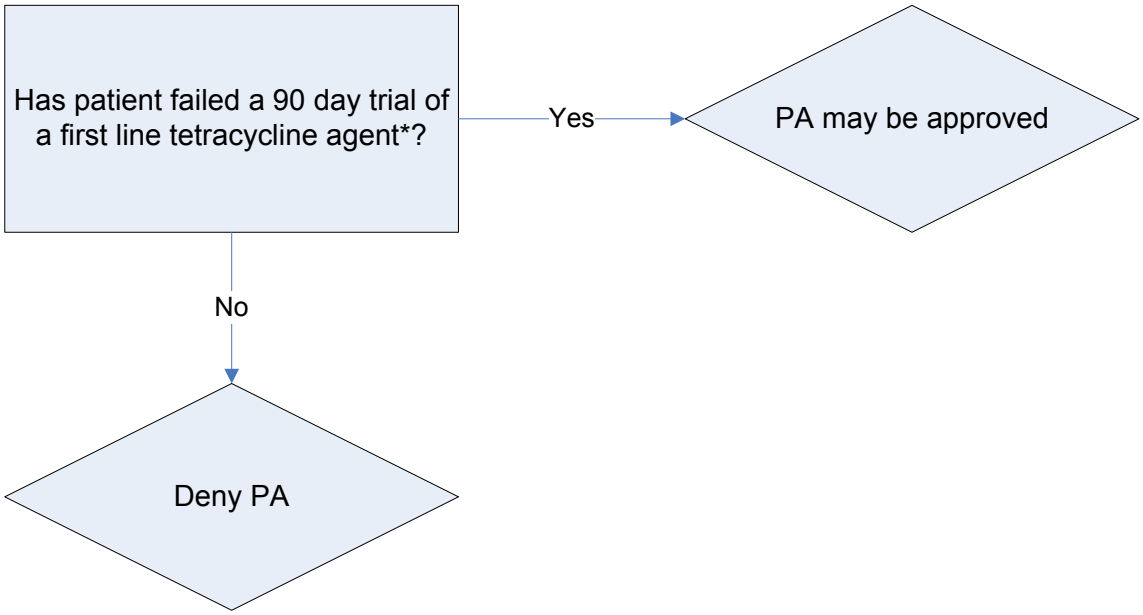
Part II: TO BE COMPLETED BY PHARMACY

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.

SUBOXONE/SUBUTEX 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 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		

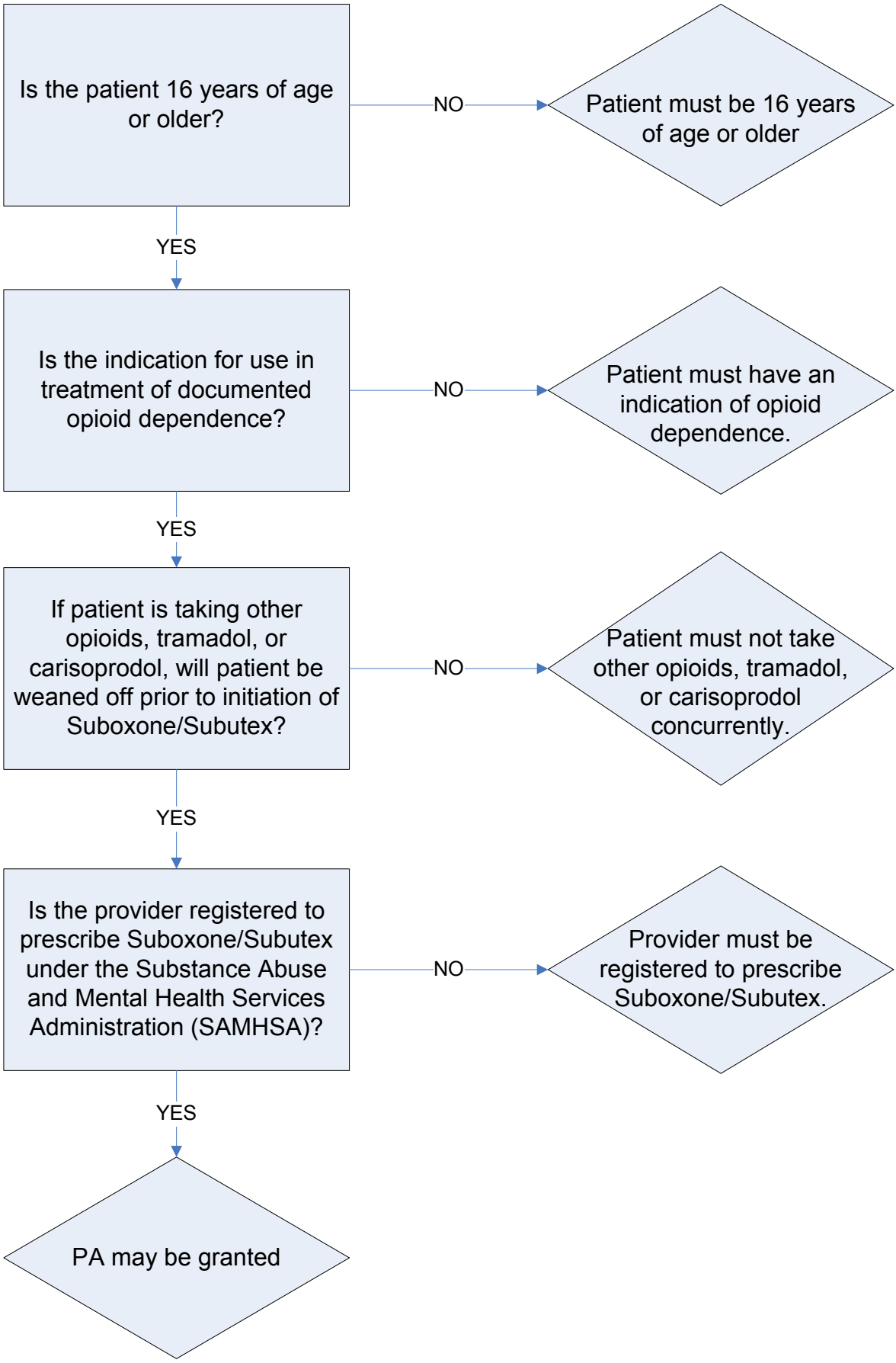
Part II: TO BE COMPLETED BY PHARMACY

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



HEALTH INFORMATION DESIGNS

SYNAGIS WEB BASED FORM

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

Prior Authorization Vendor for ND Medicaid

Note:

- Synagis season will be October 19th through April 21st
- Based on the 2009 American Academy of Pediatrics *Policy Statement – Modified Recommendations for Use of Palivizumab for Prevention of Respiratory Syncytial Virus Infections**, a maximum of 5 or 3 doses will be allowed during the Synagis season determined by gestational age.
- Providers will choose when to start dosing Synagis based on prevalence of RSV in the community

TO BE COMPLETED BY PRESCRIBER

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

Diagnosis (qualification for Synagis)

___ Prematurity

≤28 weeks, 6 days gestational age – Synagis allowed if younger than 12 months of age at start of RSV season (max of 5 doses)

29-31 weeks, 6 days gestational age – Synagis allowed if younger than 6 months of age at start of RSV season (max of 5 doses)

32-34 weeks, 6 days gestational age – Synagis allowed during RSV season up to 6 months of life (max of 3 doses)

Gestational Age (e.g. 32 weeks, 4 days)

Weeks _____ **Days** _____

Risk Factor(s) (for those 32-34 weeks, 6 days)

___ Daycare attendance

___ Sibling younger than 5 years of age

___ Chronic Lung Disease of Prematurity (CLD)

Must be less than 24 months of age and receive medical therapy within six months before start of RSV season

___ Supplemental Oxygen

___ Bronchodilator

___ Diuretic

___ Chronic corticosteroid therapy

___ Congenital Heart Disease (CHD)

Must be less than 24 months of age and requiring medical therapy for CHD

Medical Therapy Required _____

___ Neuromuscular disease

___ Congenital abnormalities of the airways

*Accessed online at http://aappolicy.aappublications.org/cgi/reprint/pediatrics;124/6/1694.pdf.

Tecfidera Prior Authorization

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

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed Tecfidera must follow these guidelines:

Note:

- ***Must have relapsing forms of multiple sclerosis.***
- ***Must have a recent CBC (within 6 months).***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Tecfidera**	**Diagnosis for this request:** **Current CBC (date):**		
Physician Signature		Date	

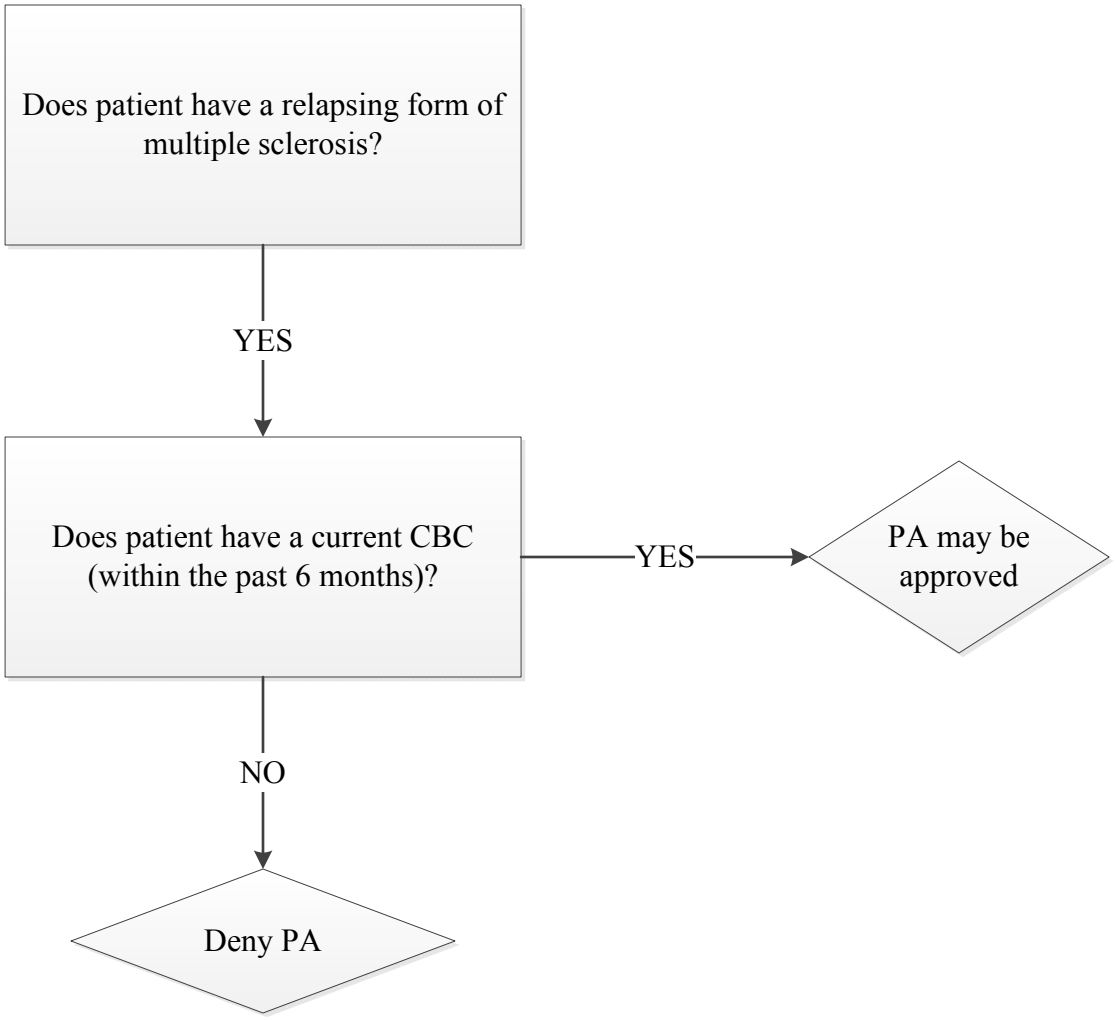
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Tecfidera Authorization Algorithm



Smoking Cessation Program

NDQuits

1-800-QUIT-NOW

Prior Authorization Vendor for ND Medicaid

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

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

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

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

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

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

TOPICAL ACNE AGENTS
PA FORM

Prior Authorization Vendor for ND Medicaid

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

ND Medicaid requires that patients receiving a new prescription for a branded topical acne agent must meet the following criteria:

- **Patients under the age of 10 or older than 35 must have a dermatologist involved in therapy**
- **Patients must first try and fail a generic topical acne agent (erythromycin, benzoyl peroxide, clindamycin, tretinoin, sodium sulfacetamide/sulfur)**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name	Dermatologist Involved in therapy (if patient is <10 and >35): Next Appointment date:		
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this Request:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber Signature	Date		

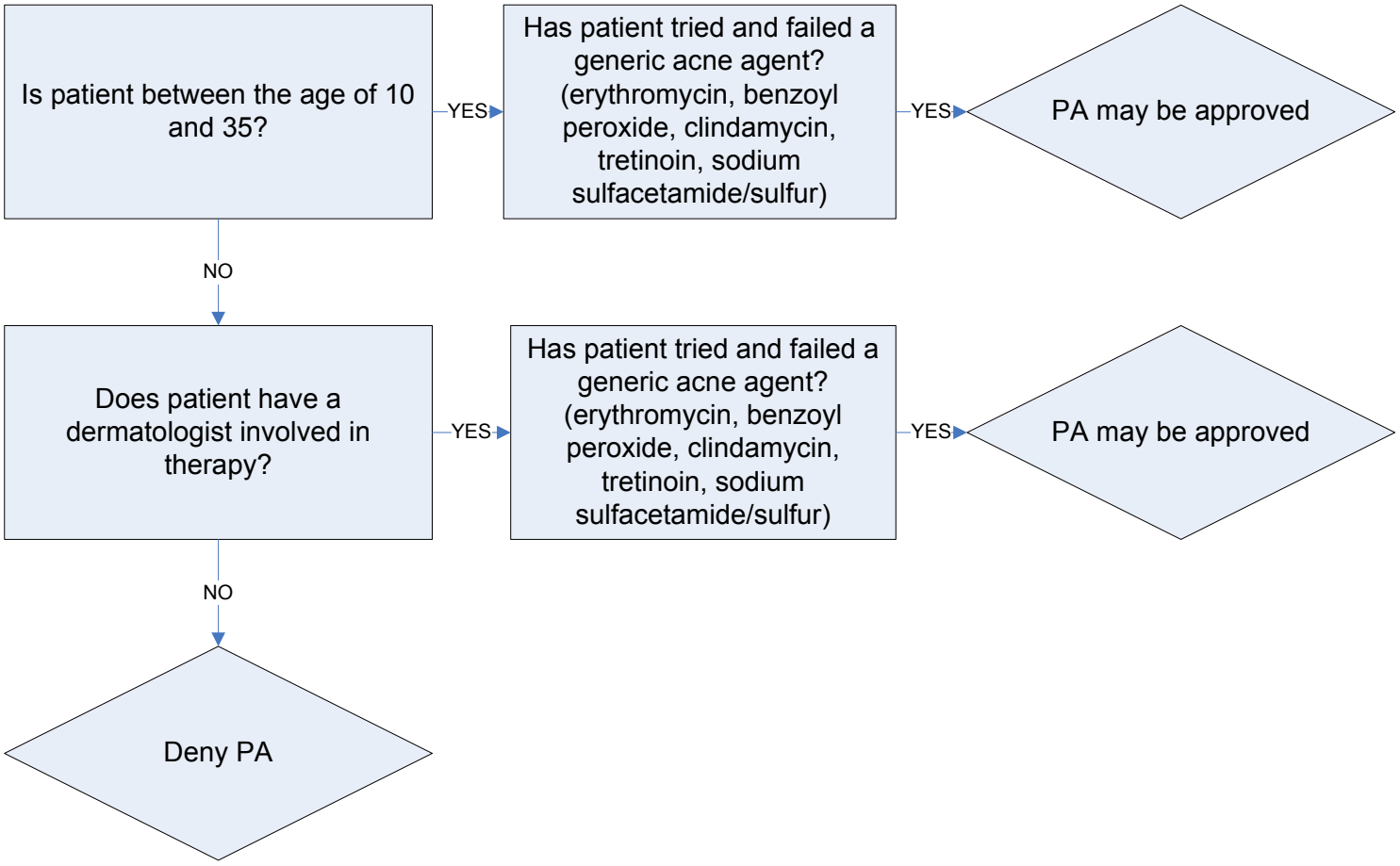
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Topical Acne Agents
Prior 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	

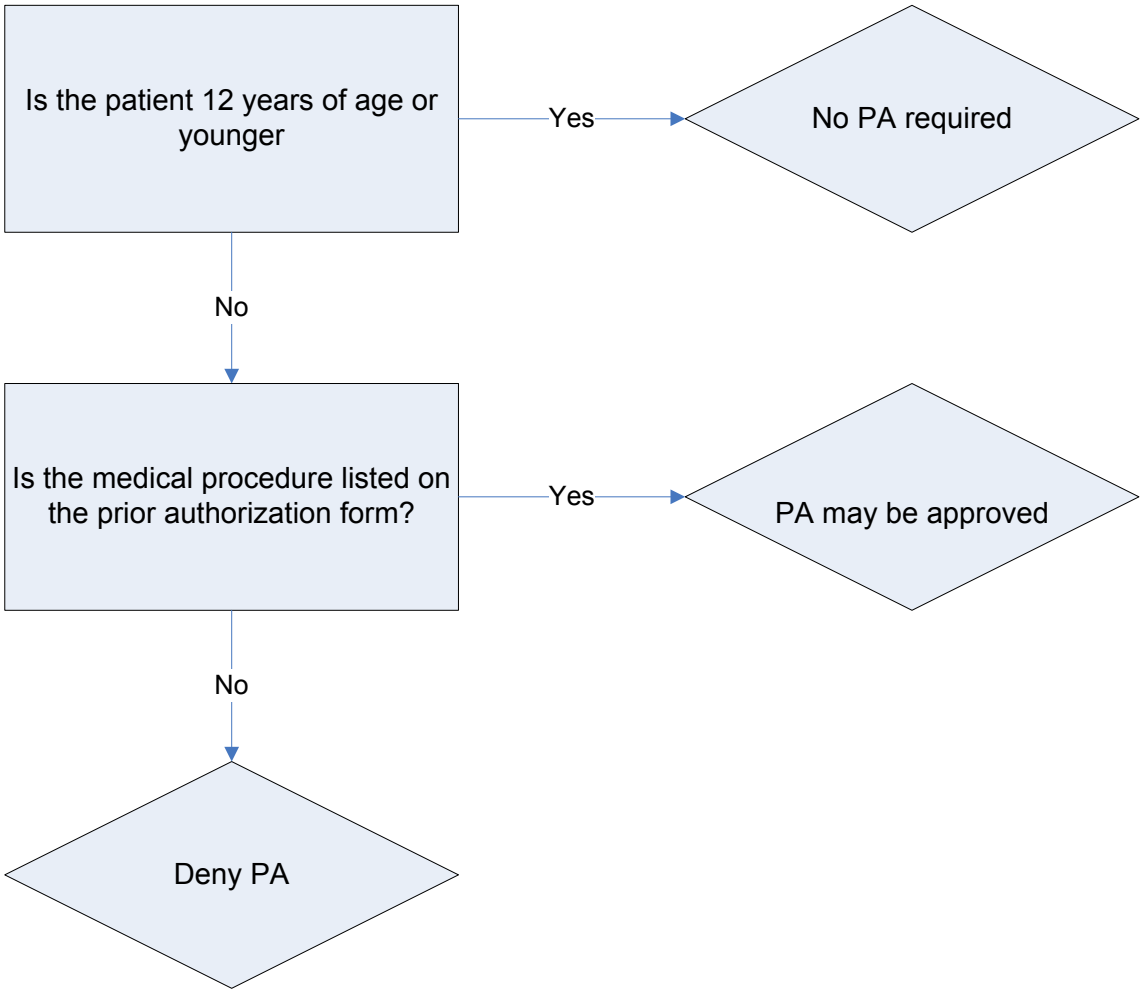
Part II: TO BE COMPLETED BY PHARMACY

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	

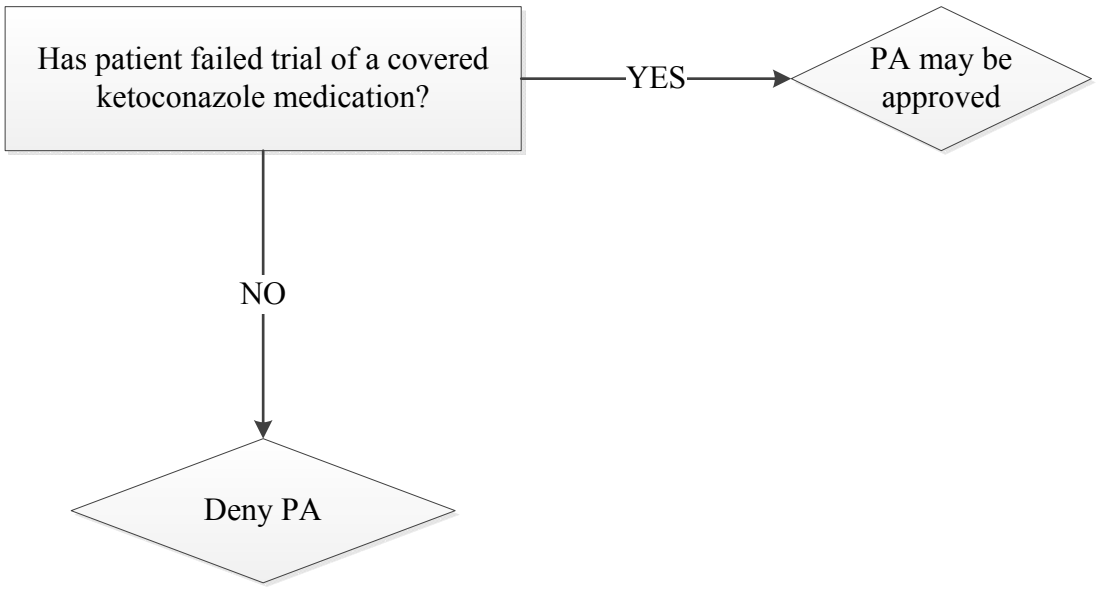
Part II: TO BE COMPLETED BY PHARMACY

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

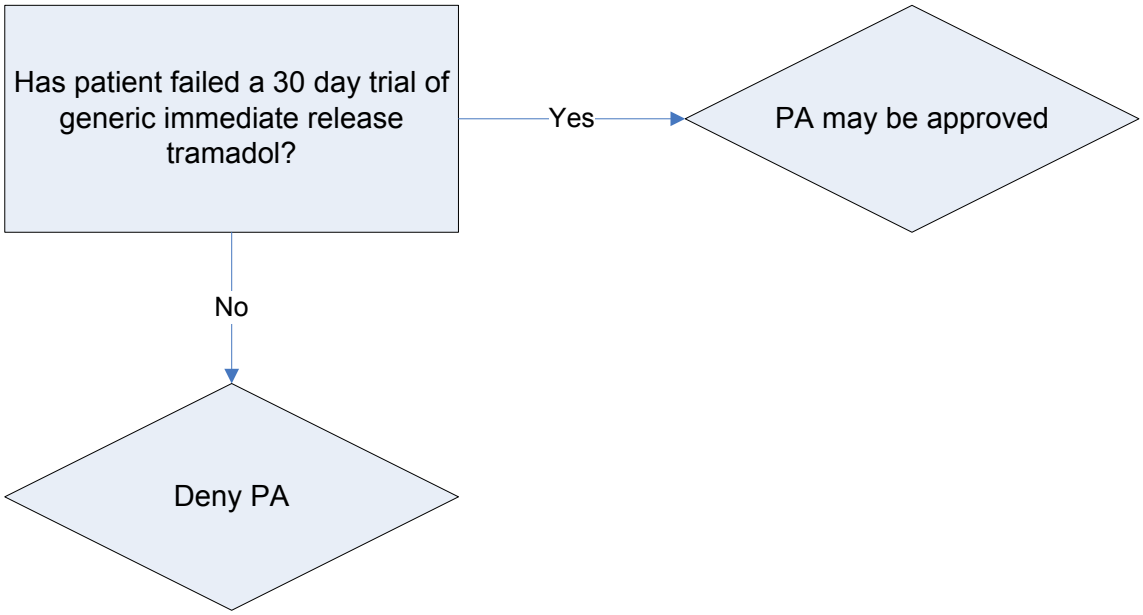
Part II: TO BE COMPLETED BY PHARMACY

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

Part I: TO BE COMPLETED BY PRESCRIBER

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

Requested Drug and Dosage:	**Diagnosis for this request:**
□ NARATRIPTAN □ 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

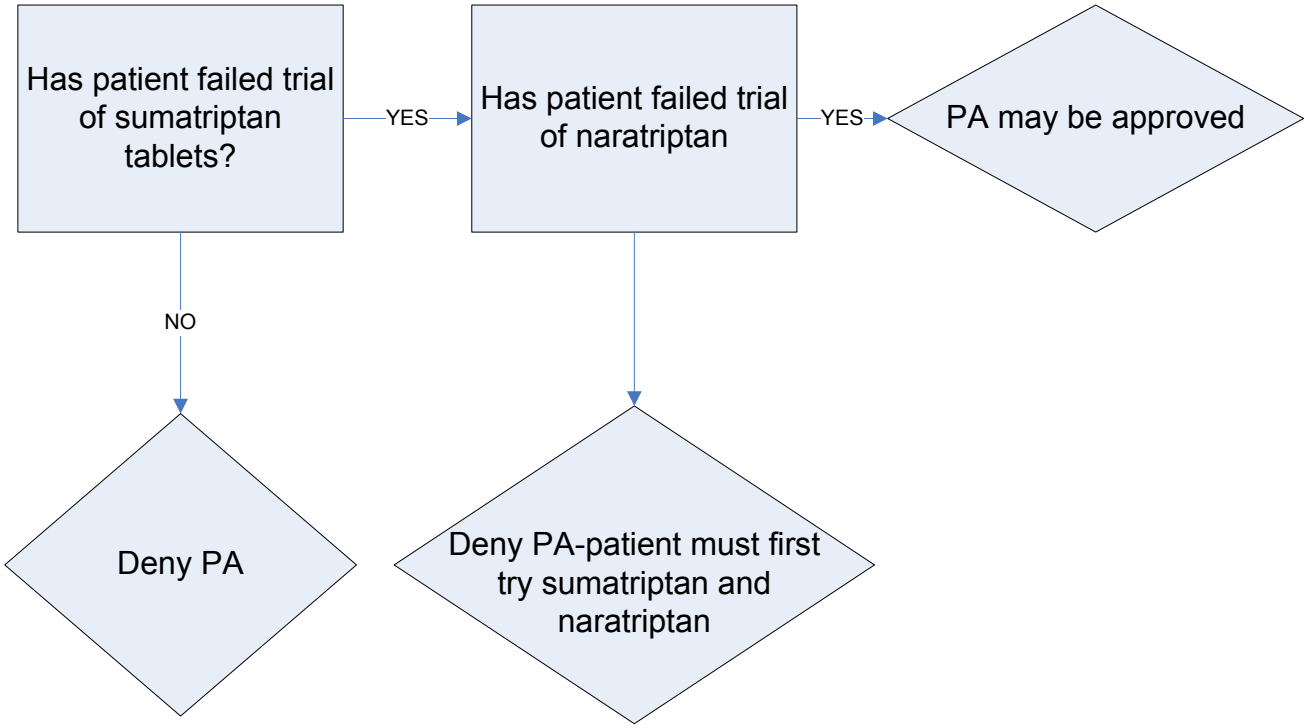
Part II: TO BE COMPLETED BY PHARMACY

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	

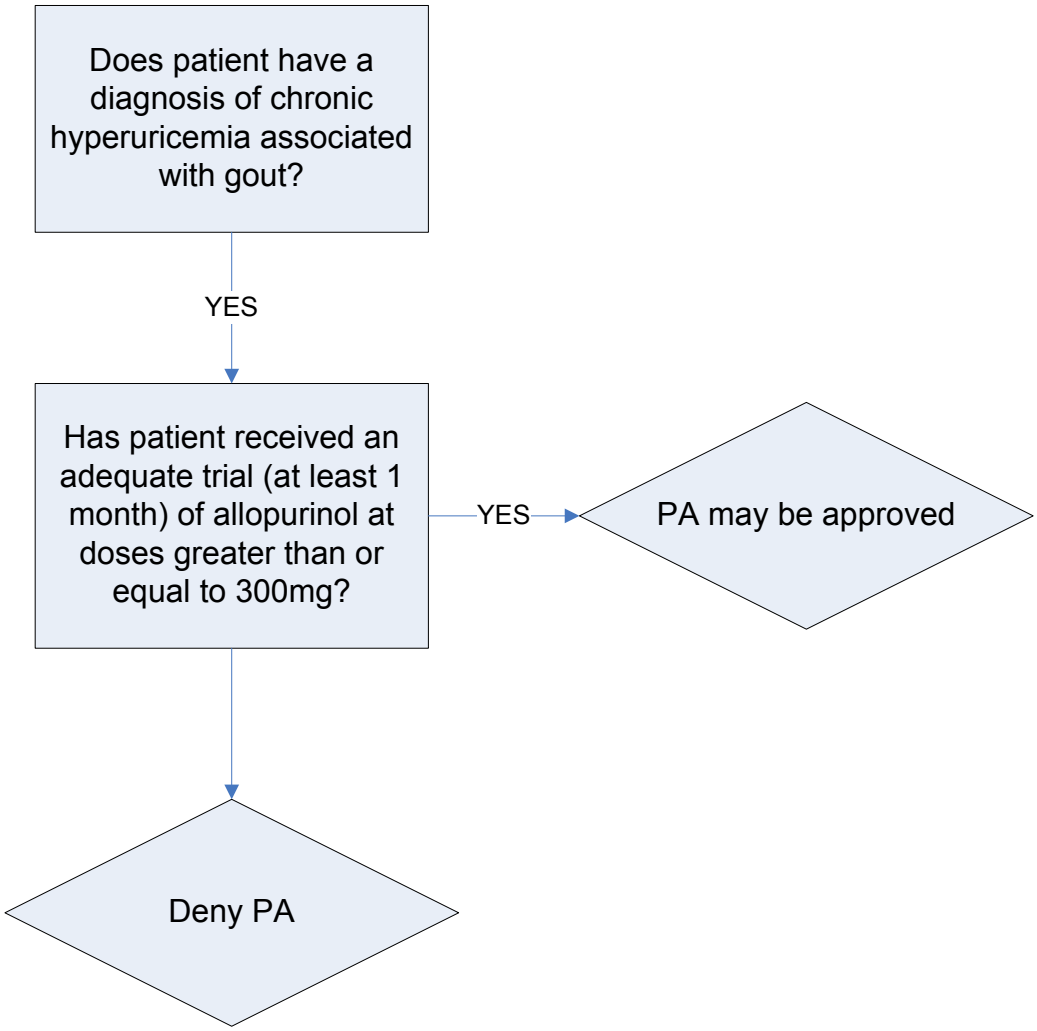
Part II: TO BE COMPLETED BY PHARMACY

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



Allopurinol does not require a prior authorization.

VANOS PA FORM

Prior Authorization Vendor for ND Medicaid

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

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

- **Patient must be 12 years of age and older.**
- **Patient must have documented failure with a generic topical steroid in the same potency class (Ultravate, Temovate, Diprolene).**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ VANOS	**Diagnosis for this Request:**		
Failed Therapy (dose and frequency): □	**Start Date:** **End Date:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber Signature		Date	

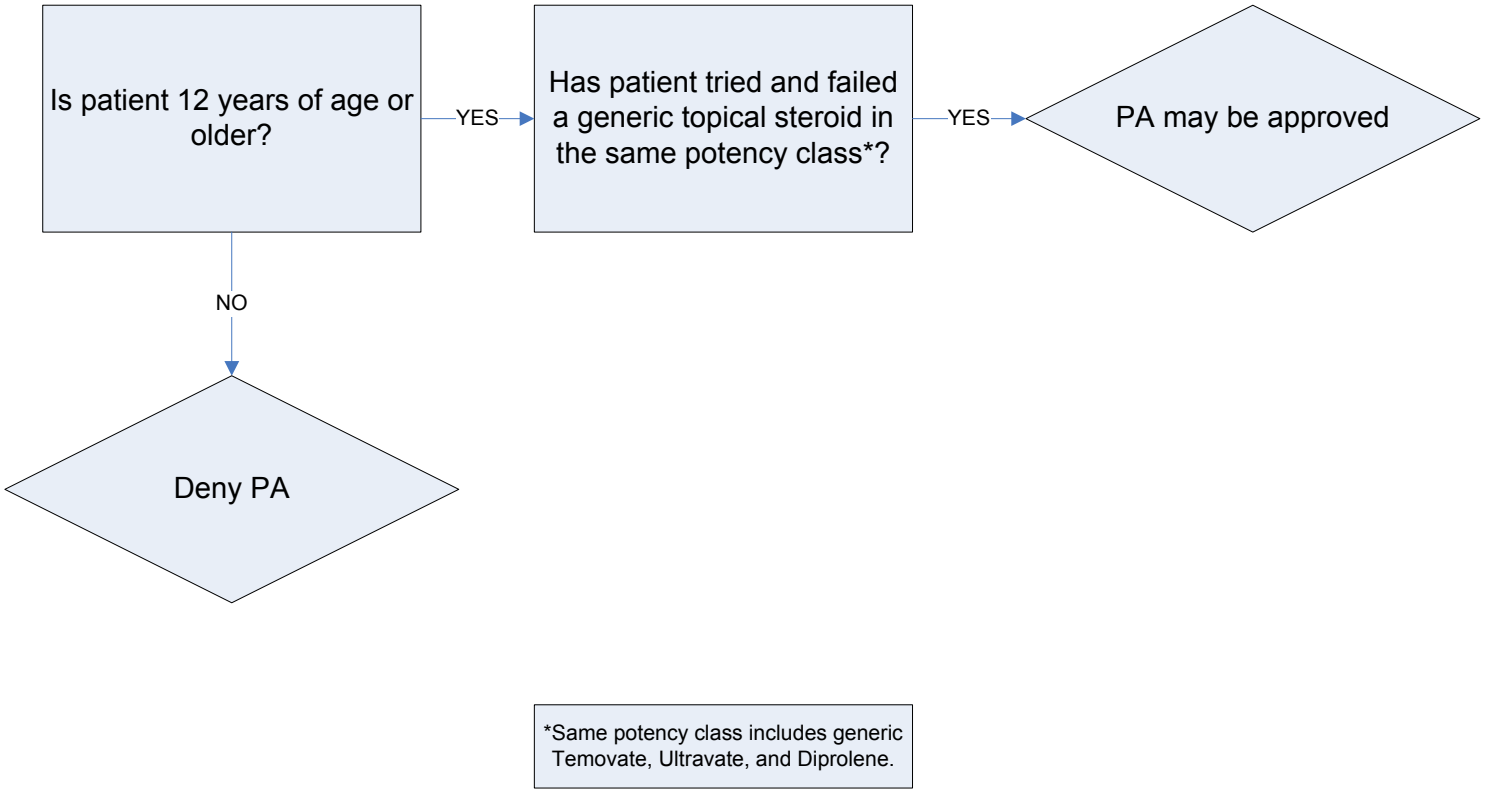
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Vanos Prior Authorization Algorithm



Vusion 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 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

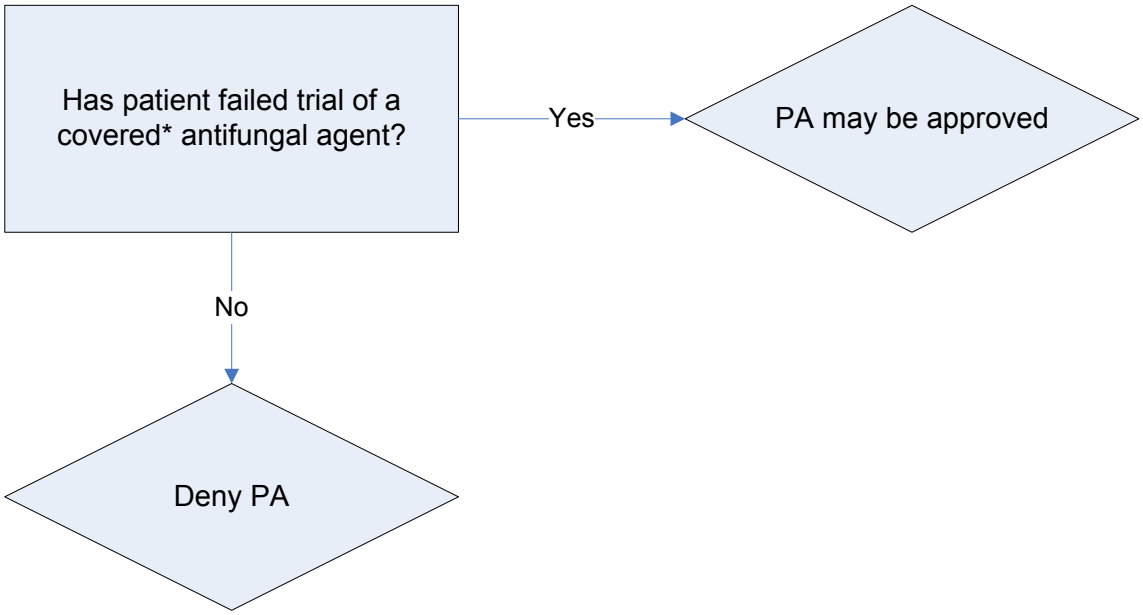
Part II: TO BE COMPLETED BY PHARMACY

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.

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Xeljanz
Prior Authorization

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

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

Note:

- **Patient must have an inadequate response or intolerance to methotrexate.**
- **Patient must have a test for latent tuberculosis prior to starting Xeljanz.**
- **Patient must have current lab monitoring prior to starting Xeljanz (CBC, liver enzymes, lipid panel)**
- **Use with caution in patients that may be at increased risk of gastrointestinal perforations.**

Part I: TO BE COMPLETED BY PHYSICIAN

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

QUALIFICATIONS FOR COVERAGE:

Requested Drug and Dosage: □ **Xeljanz**	Diagnosis for this request:
TB test in the past 6 months □ Yes □ No Lab monitoring has occurred and measurements within acceptable limits (i.e., lymphocytes, neutrophils, hemoglobin, lipids, and liver enzymes) □ Yes □ NO Has or has had active hepatitis B or C virus □ Yes □ NO	Failed methotrexate therapy Start date: End date:
Physician Signature	Date

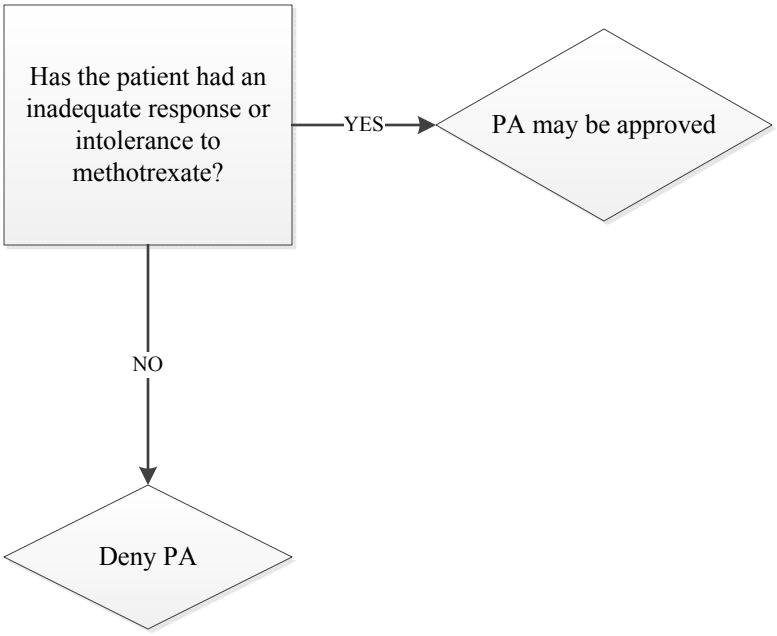
Part II: TO BE COMPLETED BY PHARMACY

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
Xeljanz Authorization Algorithm



HEALTH INFORMATION DESIGNS

Xenical Prior Authorization

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

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a prescription for Xenical must be seen by a dietician.
Note:

- ***Patient must have dietician evaluation attached to PA form including height and weight.***
- ***BMI must be equal to or greater than 40.***
- ***5% weight loss must be realized for continued approval (every 6 months).***

Part I: TO BE COMPLETED BY PRESCRIBER

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

Qualifications for coverage:			
□ Dietician evaluation attached	Height:	Weight:	BMI:
Prescriber Signature		Date	

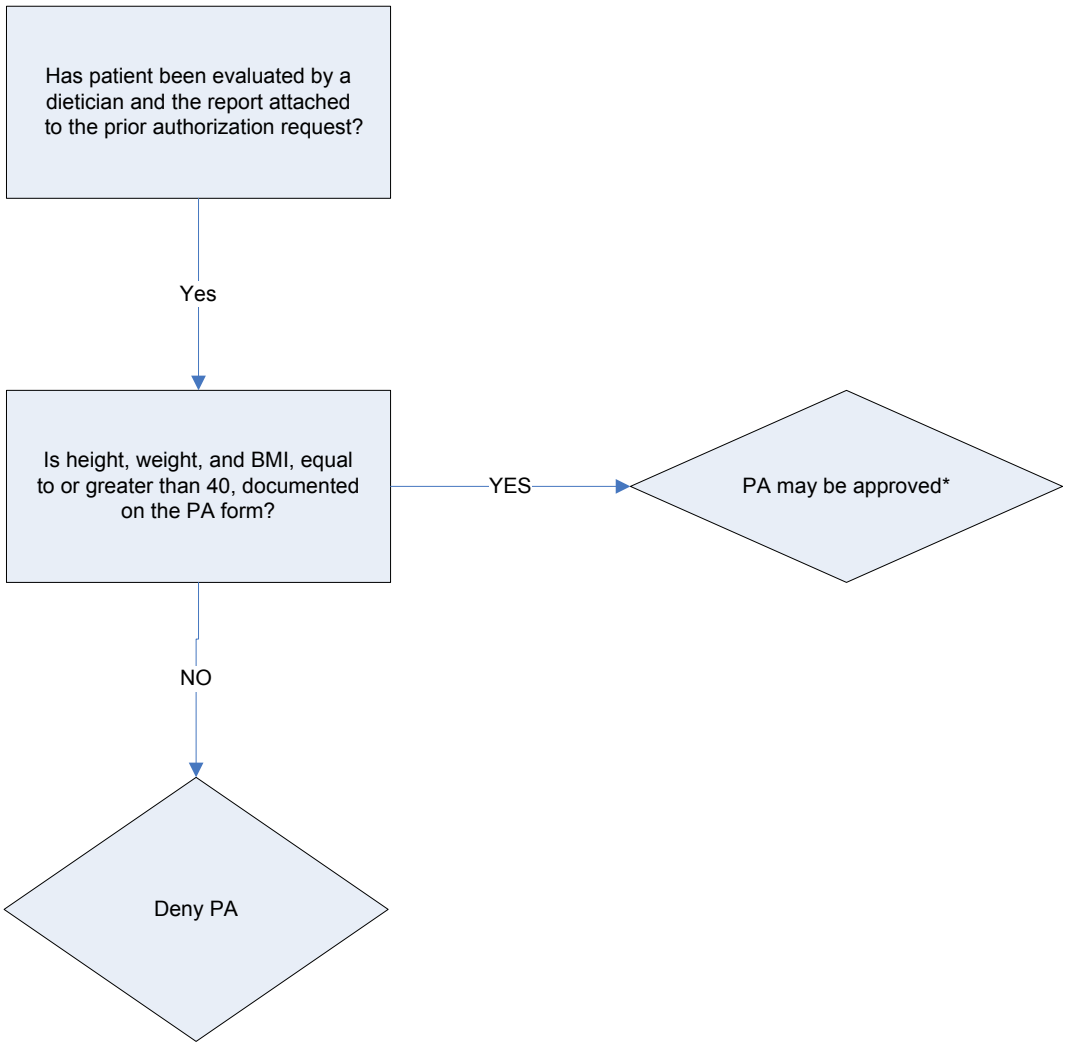
Part II: TO BE COMPLETED BY PHARMACY

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.

XIFAXAN 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 Xifaxan must meet the following guidelines:

- Patient must be 12 years of age or older and have a diagnosis of traveler's diarrhea caused by noninvasive strains of E. coli.
- Patient must be 18 years of age or older and have a risk of recurrence of overt hepatic encephalopathy.
- Do not use in patients with diarrhea complicated by fever or blood in the stool or diarrhea due to pathogens other than E. coli.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ XIFAXAN	**Diagnosis for this Request:** □ TRAVELER'S DIARRHEA: 200 mg three times a day for 3 days □ HEPATIC ENCEPHALOPATHY: 550 mg two times a day		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber Signature		Date	

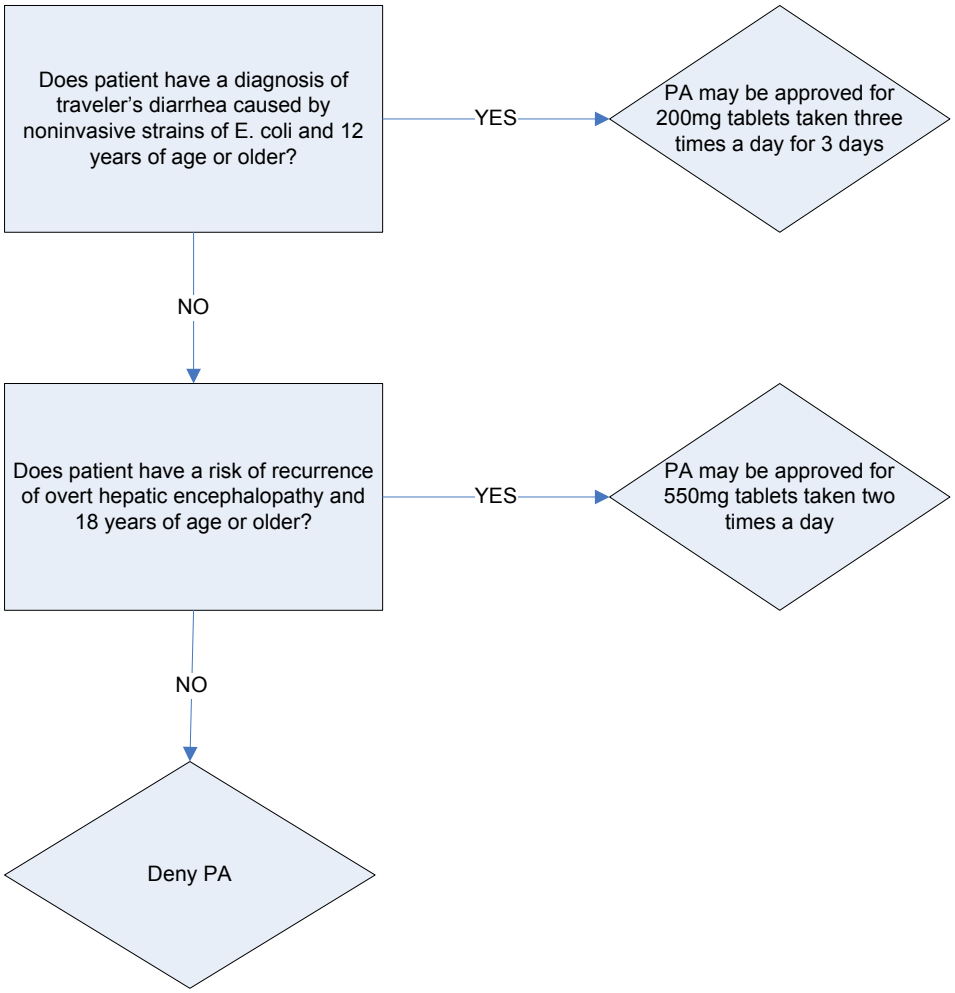
Part II: TO BE COMPLETED BY PHARMACY

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

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Xifaxan Prior Authorization Algorithm



XOLAIR 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 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

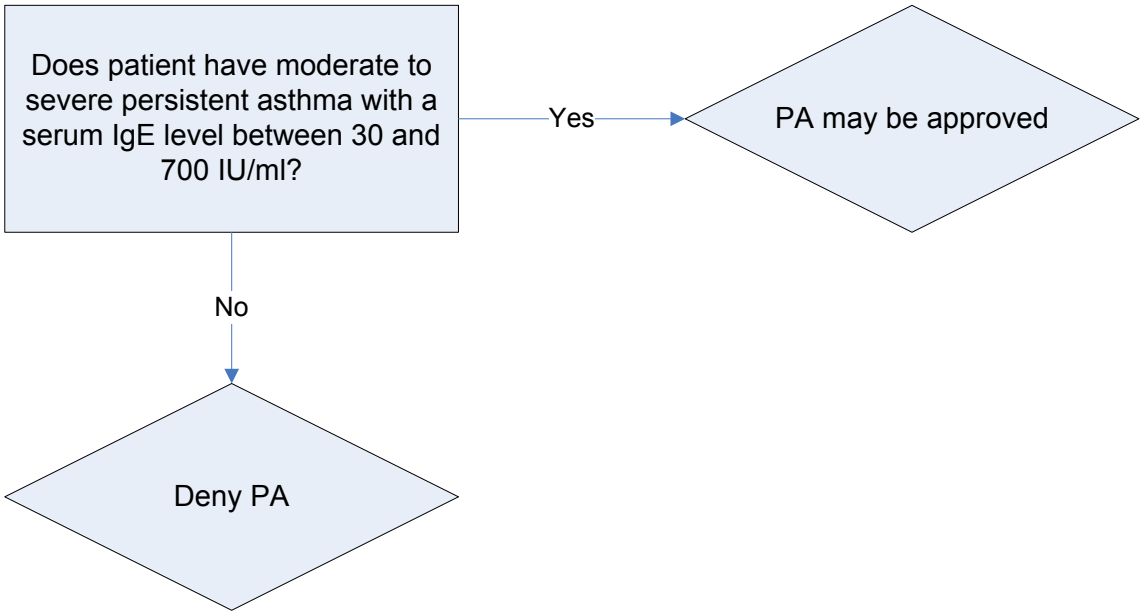
Part II: TO BE COMPLETED BY PHARMACY

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	

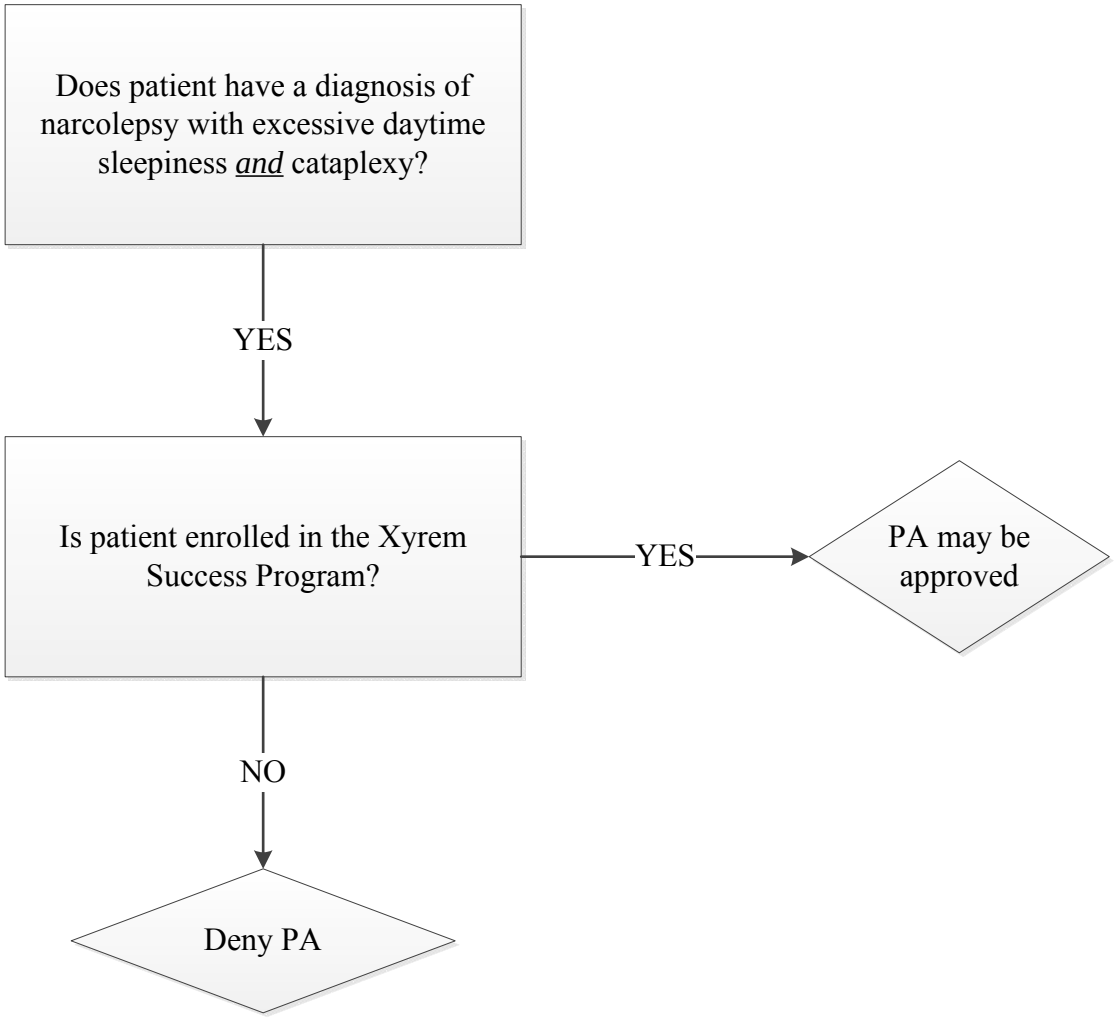
Part II: TO BE COMPLETED BY PHARMACY

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	

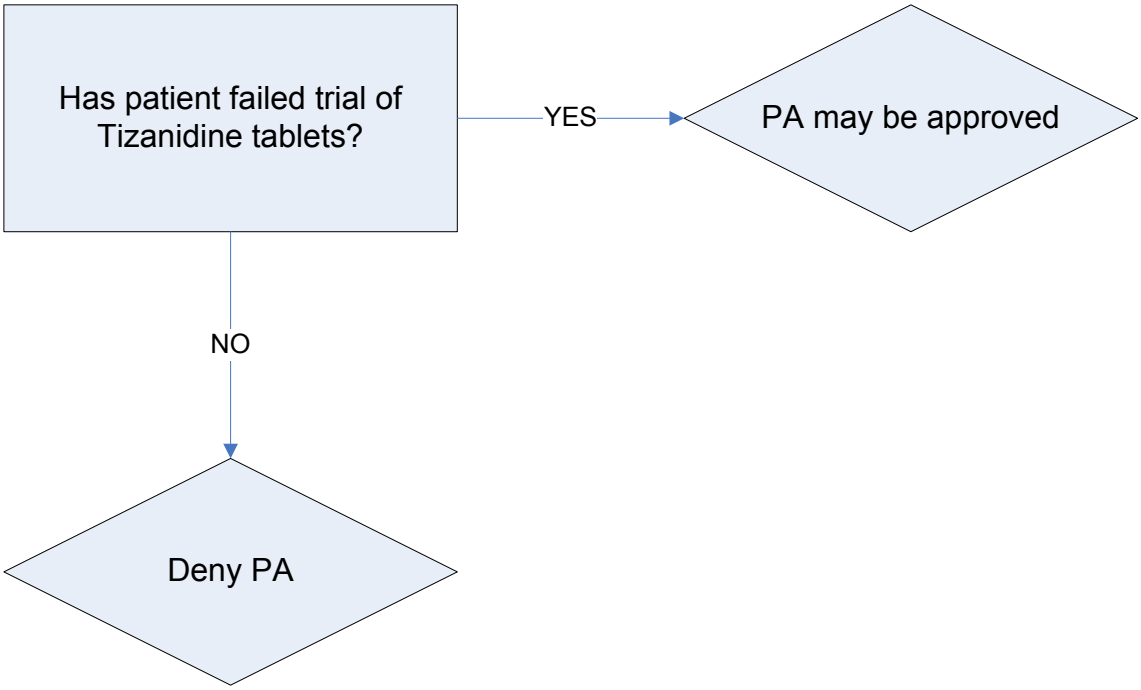
Part II: TO BE COMPLETED BY PHARMACY

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



NORTH DAKOTA MEDICAID
RETROSPECTIVE DRUG UTILIZATION REVIEW
CRITERIA RECOMMENDATIONS
4TH QUARTER 2013

Criteria Recommendations ***Approved Rejected***

1. Telaprevir / Peginterferon Alfa and Ribavirin (Negating) _____ _____

Alert Message: A review of the patient's recent drug history does not indicate the concurrent use of Incivek (telaprevir) with peginterferon alfa and ribavirin. Telaprevir must not be used as monotherapy due to the risk of the selection of resistant mutants which may be followed by viral breakthrough. Combination therapy with peginterferon alfa and ribavirin reduces the frequency of resistance development.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Telaprevir		Peginterferon alfa
		Ribavirin

References:
Sarrazin C, Zeuzem S. Resistance to Direct Antiviral Agents in Patients with Hepatitis C Infection. Gastroenterology. 2010 Feb;138(2):447-62.
Sarrazin C, Kieffer TL, Bartels D, et al. Dynamic Hepatitis C Virus Genotypic and Phenotypic Changes in Patients Treated with the Protease Inhibitor Telaprevir. Gastroenterology. 2007;132:1767-77
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

2. Telaprevir / Pregnancy / Miscarriage-Delivery-Abortion _____ _____

Alert Message: Incivek (telaprevir) in combination with peginterferon alfa and ribavirin is contraindicated in pregnant women and in men whose female partners are pregnant (Pregnancy Category X). Women of childbearing potential and men must use at least two forms of effective contraception during treatment and for at least 6 months after treatment has concluded.

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

Util A	Util B	Util C **(Negating)**
Telaprevir	Pregnancy	Miscarriage
		Delivery
		Abortion

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

3. Telaprevir / Drugs Highly Dependent on CYP3A for Clearance _____ _____

Alert Message: The concurrent use of Incivek (telaprevir) is contraindicated with drugs that are highly dependent on CYP3A4/5 for clearance, and for which elevated plasma concentrations are associated with serious and/or life threatening reactions. Telaprevir is a potent CYP3A4 inhibitor and co-administration with drugs requiring CYP3A4 for metabolism may cause large increases in serum concentrations of the CYP3A4/5 substrate.

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

Util A	Util B	Util C
Telaprevir	Alfuzosin	
	Dihydroergotamine	
	Ergotamine	
	Methylergonovine	
	Lovastatin	
	Simvastatin	
	Sildenafil (Revatio)	
	Tadalafil (Adcirca)	
	Pimozide	
	Triazolam	
	Midazolam-oral	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

4. Telaprevir / Potent CYP3A Inducers _____ _____

Alert Message: The concurrent use of Incivek (telaprevir) with the potent CYP3A4 inducer rifampin is contraindicated. Telaprevir is a CYP3A4 substrate and co-administration with rifampin significantly reduces telaprevir plasma concentrations and may lead to loss of virologic response.

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

Util A	Util B	Util C
Telaprevir	Rifampin	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

5. Ketoconazole & Itraconazole / Telaprevir _____ _____

Alert Message: The concurrent use of Incivek (telaprevir) with ketoconazole or itraconazole may result in increased plasma concentrations of telaprevir and the antifungal, as all are substrates and inhibitors of CYP3A4. When co-administered with telaprevir the dosages of itraconazole or ketoconazole should not exceed 200 mg /day.

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

Util A	Util B	Util C **(Include)**
Ketoconazole		Telaprevir
Itraconazole		

Max Dose of Antifungal: 200mg/day

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

6. Telaprevir / Posaconazole _____ _____

Alert Message: The concurrent use of Incivek (telaprevir) with Noxafil (posaconazole) may result in elevated plasma concentrations of both telaprevir and posaconazole, increasing the risk of adverse effects which includes posaconazole-related QT interval prolongation and torsade de pointes. Clinical monitoring is advised during concurrent use of these agents.

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

Util A	Util B	Util C
Telaprevir	Posaconazole	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

7. Telaprevir / Voriconazole _____ _____

Alert Message: The concurrent use of Incivek (telaprevir) with voriconazole is not recommended unless an assessment of the benefit /risk ratio justifies its use.
Co-administration may result in increased plasma concentrations of telaprevir and increased risk of telaprevir-related adverse effects. Voriconazole levels can be increased or decreased leading to either increased risk of voriconazole adverse effects (e.g., QT prolongation or torsade de points) or decreased voriconazole efficacy.

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

Util A	Util B	Util C
Telaprevir	Voriconazole	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

8. Telaprevir / P-gp, CYP3A4 and/or OATP1B1 & 2 Substrates _____ _____

Alert Message: Incivek (telaprevir) is a strong CYP3A4 inhibitor and an inhibitor of P-glycoprotein (P-gp), OATP1B1 and OATP2B1. Concurrent use of telaprevir with drugs that are substrates of these pathways may result in increased plasma concentrations of the substrate, resulting in increased risk of adverse effects. Dosage adjustment of the substrate may be required during telaprevir therapy and readjustment after completion of telaprevir therapy.

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

Util A	Util B	Util C
Telaprevir	Afatinib (Pg-p)	Trazodone (3A4)
	Aliskiren (3A4)	Ziprasidone (3A4)
	Fexofenadine (3A4 OAT1B1)	Escitalopram (3A4)
	Ondansetron (P-gp & 3A4)	Citalopram (3A4)
	Acetaminophen (3A4)	Repaglinide (3A4 & OAT1B1)
	Almotriptan (3A4)	
	Buprenorphine (3A4)	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

9. Telaprevir / Digoxin _____ _____

Alert Message: The concurrent use of Incivek (telaprevir), a P-gp inhibitor, and digoxin, a P-gp substrate, may cause elevated digoxin concentrations, increasing the risk of digoxin-related adverse events. If concurrent use is required the lowest dose of digoxin should be prescribed initially. The serum digoxin concentrations should be monitored and used for titration of digoxin to obtain the desired clinical effect.

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

Util A	Util B	Util C
Telaprevir	Digoxin	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

10. Telaprevir / Antiarrhythmics _____ _____

Alert Message: The concurrent use of Incivek (telaprevir), a potent CYP3A4 inhibitor, and CYP3A4-metabolized antiarrhythmics may result in serious and/or life threatening adverse events. Caution is warranted and clinical monitoring is recommended when these agents are used concomitantly with telaprevir.

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

Util A	Util B	Util C
Telaprevir	Amiodarone	
	Flecainide	
	Propafenone	
	Quinidine	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

11. Telaprevir / Warfarin _____ _____

Alert Message: The concurrent use of Incivek (telaprevir) and warfarin may cause alterations (increases or decreases) in the warfarin plasma concentrations. When these drugs are co-administered monitor INR closely and adjust warfarin dose if necessary.

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

Util A	Util B	Util C
Telaprevir	Warfarin	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

12. Telaprevir / Carbamazepine _____ _____

Alert Message: The concurrent use of Incivek (telaprevir) and carbamazepine may result in increased carbamazepine plasma concentrations and decreased telaprevir plasma concentrations. Clinical or laboratory monitoring of carbamazepine concentrations and dose titration are recommended to achieve the desired clinical response.

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

Util A	Util B	Util C
Telaprevir	Carbamazepine	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

13. Telaprevir / Phenytoin & Phenobarbital _____ _____

Alert Message: The concurrent use of Incivek (telaprevir) and phenytoin or phenobarbital may result in altered phenytoin and phenobarbital plasma concentrations (increase or decrease) and decreased telaprevir plasma concentrations. Clinical or laboratory monitoring of the anticonvulsant concentrations and dose titration are recommended to achieve the desired clinical response.

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

Util A	Util B	Util C
Telaprevir	Phenytoin Phenobarbital	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

14. Telaprevir / Trazodone _____ _____

Alert Message: The concurrent use of Incivek (telaprevir), a potent CYP3A4 inhibitor, and CYP3A4 substrate trazodone may result in elevated trazodone plasma concentrations, increasing risk of adverse events. Dosage adjustment of trazodone may be necessary during concurrent therapy with telaprevir.

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

Util A	Util B	Util C
Telaprevir	Trazodone	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

15. Telaprevir / Colchicine / Renal or Hepatic Impairment Negating _____ _____

Alert Message: The concurrent use of Incivek (telaprevir), a potent CYP3A4 inhibitor, and the CYP3A4 substrate colchicine may result in elevated colchicine plasma concentrations, increasing the risk of fatal colchicine toxicity. A reduction in colchicine dosage or an interruption of colchicine treatment is recommended in patients with normal renal or hepatic function. Please see the manufacturer's specific dosing information for the use of colchicine.

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

Util A	Util B	Util C **(Negating)**
Telaprevir	Colchicine	Renal Impairment
		Hepatic Impairment

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

16. Telaprevir / Colchicine / Renal or Hepatic Impairment (Include) _____ _____

Alert Message: The concurrent use of Incivek (telaprevir), a potent CYP3A4 inhibitor, and the CYP3A4 substrate colchicine may result in elevated colchicine plasma concentrations, increasing the risk of fatal colchicine toxicity. Patients with renal or hepatic impairment should not be prescribed colchicine with telaprevir.

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

Util A	Util B	Util C **(Include)**
Telaprevir	Colchicine	Renal Impairment
		Hepatic Impairment

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

17. Telaprevir / CYP3A4 Substrate CCBs _____ _____

Alert Message: The concurrent use of Incivek (telaprevir), a potent CYP3A4 inhibitor, and a CYP3A4 substrate calcium channel blocker (CCB) may result in elevated CCB plasma concentrations, increasing risk of CCB-related adverse events. Caution is warranted and clinical monitoring is recommended. Dosage reductions may be necessary if the CCB co-administered is amlodipine.

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

Util A	Util B	Util C
Telaprevir	Amlodipine	
	Felodipine	
	Nicardipine	
	Nifedipine	
	Nisoldipine	
	Diltiazem	
	Verapamil	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

18. Telaprevir / Prednisone & Methylprednisolone _____ _____

Alert Message: The concurrent use of Incivek (telaprevir) with prednisone or methylprednisolone is not recommended. The systemic corticosteroids are CYP3A4 substrates and co-administration with telaprevir, a potent CYP3A4 inhibitor, may result in significantly increased corticosteroid plasma concentrations.

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

Util A	Util B	Util C
Telaprevir	Prednisone	
	Methylprednisolone	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

19. Telaprevir / Dexamethasone _____ _____

Alert Message: The concurrent use of Incivek (telaprevir), a CYP3A4 substrate, and dexamethasone, a CYP3A4 inducer, may result in decreased telaprevir plasma concentrations and loss of virologic activity. The combination of telaprevir and dexamethasone should be used with caution or alternatives should be considered.

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

Util A	Util B	Util C
Telaprevir	Dexamethasone	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

20. Telaprevir / Inhaled & Nasal Corticosteroids Fluticasone & Budesonide _____ _____

Alert Message: The concurrent use of Incivek (telaprevir) with the inhaled or nasal corticosteroids budesonide or fluticasone may cause increased plasma concentrations of the corticosteroid, resulting in significantly reduced serum cortisol concentrations. Co-administration of these agents is not recommended unless the potential benefit to the patient outweighs the risk of systemic corticosteroid side effects.

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

Util A	Util B	Util C
Telaprevir	Fluticasone-Inhaled & Nasal	
	Budesonide-Inhaled & Nasal	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

21. Telaprevir / Bosentan _____ _____

Alert Message: The concurrent use of Incivek (telaprevir) with Tracleer (bosentan) may result in elevated bosentan plasma concentrations leading to increased risk of bosentan-related adverse events. Caution is warranted and clinical monitoring is recommended.

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

Util A	Util B	Util C
Telaprevir	Bosentan	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

22. Telaprevir / Efavirenz _____ _____

Alert Message: The concurrent use of Incivek (telaprevir) and Sustiva (efavirenz) may result in decreased exposure to both telaprevir and efavirenz. HIV guidelines recommend that the telaprevir dose be increased to 1125 mg every 8 hours along with close clinical monitoring during co-administration due to potential for HIV and hepatitis C treatment failure.

Conflict Code: LR – Low Dose
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Telaprevir		Efavirenz

Dose/day: < 1125mg/day of telaprevir

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals 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. February 12, 2013;1-167. Available at http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf.

23. Telaprevir / Atripla _____ _____

Alert Message: The concurrent use of Incivek (telaprevir) and Atripla (efavirenz/ emtricitabine/tenofovir) may result in the decreased exposure to both efavirenz and telaprevir and increased exposure to tenofovir.

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

Util A	Util B	Util C
Telaprevir	Atripla	

References:
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

24. Telaprevir / Tenofovir-Containing Agents _____ _____

Alert Message: The concurrent use of Incivek (telaprevir) and a tenofovir-containing agent (i.e., Viread, Truvada, Complera or Atripla) may result in increased tenofovir exposure and risk for tenofovir-related adverse effects. Increased clinical and laboratory monitoring are warranted.

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

Util A	Util B	Util C
Telaprevir	Tenofovir	
	Tenofovir/Emtricitabine	
	Tenofovir/Emtricitabine/Efavirenz	
	Tenofovir/Rilpivirine/Emtricitabine	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

25. Telaprevir / Immunosuppressants _____ _____

Alert Message: The concurrent use of Incivek (telaprevir), a potent CYP3A4 inhibitor, with a CYP3A4 substrate immunosuppressant may result in elevated plasma concentrations of the CYP3A4 substrate, increasing the risk of immunosuppressant-related adverse events. Close monitoring of immunosuppressant blood levels is recommended.

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

Util A	Util B	Util C
Telaprevir	Cyclosporine	
	Tacrolimus	
	Sirolimus	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

26. Telaprevir / Salmeterol _____ _____

Alert Message: The concurrent use of Incivek (telaprevir) with a salmeterol-containing agent is not recommended due to the risk of adverse cardiovascular events associated with salmeterol. Telaprevir is a potent CYP3A4 inhibitor and use with the CYP3A4 substrate salmeterol can result in elevated salmeterol plasma concentrations.

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

Util A	Util B	Util C
Telaprevir	Salmeterol	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

27. Telaprevir / Methadone _____ _____

Alert Message: The concurrent use of methadone with Incivek (telaprevir) may result in reduced plasma concentrations of methadone. Clinical monitoring is recommended as the dose of methadone during maintenance therapy may need to be adjusted in some patients.

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

Util A	Util B	Util C
Telaprevir	Methadone	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

28. Telaprevir / Ethinyl Estradiol Contraceptives _____ _____

Alert Message: The concurrent use of Incivek (telaprevir) and ethinyl estradiol contraceptives may result in decreased ethinyl estradiol plasma concentrations with the potential of birth control failure in women with childbearing potential. Systemic hormonal contraception must be augmented by 2 alternative effective forms of contraception and may include intrauterine devices and barrier methods during therapy and for 6 months following therapy.

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

Util A	Util B	Util C
Telaprevir	EE- containing contraceptives	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

29. Telaprevir / PDE5 for ED _____ _____

Alert Message: The concurrent use of Incivek (telaprevir) and a PDE5 inhibitor for the treatment of ED may result in increased PDE5 inhibitor plasma concentrations and risk of serious PDE5 inhibitor-related adverse events. Do not exceed the following doses for PDE5 inhibitors when used with telaprevir: sildenafil - 25 mg every 48 hours, tadalafil -10 mg every 72 hours and vardenafil - 2.5 mg every 24 hours.

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

Util A	Util B	Util C
Telaprevir	Vardenafil 5, 10 & 20mg	
	Sildenafil 50& 100 mg	
	Tadalafil 20mg	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

30. Telaprevir / Alprazolam _____ _____

Alert Message: The concurrent use of Incivek (telaprevir) with alprazolam may result in elevated alprazolam serum concentrations and risk of alprazolam-related adverse events. Clinical monitoring is warranted.

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

Util A	Util B	Util C
Telaprevir	Alprazolam	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

31. Telaprevir / Zolpidem _____ _____

result in decreased zolpidem exposure. Clinical monitoring and dose titration of zolpidem is recommended to achieve the desired clinical response.

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

Util A	Util B	Util C
Telaprevir	Zolpidem	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

32. Telaprevir / Rifabutin _____ _____

Alert Message: The concurrent use of Incivek (telaprevir) with rifabutin is not recommended. Co-administration of these agents may result in elevated rifabutin plasma concentrations and decreased telaprevir concentrations. Both agents are CYP3A4 substrates and telaprevir is a potent CYP3A4 inhibitor while rifabutin is a CYP3A4 inducer.

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

Util A	Util B	Util C
Telaprevir	Rifabutin	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

33. Telaprevir / Darunavir / Ritonavir _____ _____

Alert Message: Concurrent use of Incivek (telaprevir) with ritonavir-boosted Prezista (darunavir) is not recommended. Co-administration of these agents has been shown to result in reduced steady-state exposure to both telaprevir and darunavir.

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

Util A	Util B	Util C **(Include)**
Telaprevir	Darunavir	Ritonavir

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

34. Telaprevir / Fosamprenavir / Ritonavir _____ _____

Alert Message: Concurrent use of Incivek (telaprevir) with ritonavir-boosted Lexiva (fosamprenavir) is not recommended. Co-administration of these agents has been shown to result in reduced steady-state exposure to both telaprevir and fosamprenavir.

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

Util A	Util B	Util C **(Include)**
Telaprevir	Fosamprenavir	Ritonavir

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

35. Telaprevir / Lopinavir-Ritonavir _____ _____

Alert Message: Concurrent use of Incivek (telaprevir) with Kaletra (lopinavir/ritonavir) is not recommended. Co-administration of these agents has been shown to result in reduced steady-state exposure to telaprevir.

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

Util A	Util B	Util C
Telaprevir	Lopinavir/Ritonavir	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

36. Telaprevir / Atazanavir / Ritonavir _____ _____

Alert Message: Concurrent use of Incivek (telaprevir) with ritonavir-boosted Reyataz (atazanavir) has been shown to result in reduced steady-state exposure to telaprevir while steady-state atazanavir exposure was increased. Monitor patient for decreased telaprevir efficacy and atazanavir-related adverse effects.

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

Util A	Util B	Util C **(Include)**
Telaprevir	Atazanavir	Ritonavir

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

37. Telaprevir / Clarithromycin, Erythromycin & Telithromycin _____ _____

Alert Message: Concurrent use of Incivek (telaprevir) with the antibacterials, clarithromycin, erythromycin or telithromycin, may result in increased plasma concentrations of telaprevir and the antibacterial agent. Caution is warranted and clinical monitoring is recommended when agents are co-administered. All three antibacterials have been shown to increase QT prolongation and clarithromycin and erythromycin are reported to cause torsade de pointes.

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

Util A	Util B	Util C
Telaprevir	Clarithromycin Erythromycin Telithromycin	

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

38. Telaprevir / Certain Statins _____ _____

Alert Message: Concurrent use of Incivek (telaprevir) with fluvastatin, pitavastatin, pravastatin or rosuvastatin may result in increased plasma concentrations of the statin, increasing the risk of statin-related adverse effects. Caution is warranted and clinical monitoring is recommended when telaprevir is co-administered with one of these statins. Telaprevir is an inhibitor of OATP1B1 and OATP2B1 transporters.

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

Util A	Util B	Util C
Telaprevir	Fluvastatin	
	Pravastatin	
	Pitavastatin	
	Rosuvastatin	

References:
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Incivek Prescribing Information, April 2013, Vertex Pharmaceuticals Inc.

39. Eletriptan / Potent CYP3A4 Inhibitors _____ _____

Alert Message: Relpax (eletriptan) is a CYP3A4 substrate and should not be used within at least 72 hours of treatment with drugs that have demonstrated potent CYP3A4 inhibition and have this effect described in the contraindications, warning and precaution section of labeling.

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

Util A	Util B			Util C
Eletriptan	Ketoconazole	Saquinavir	Tipranavir	
	Itraconazole	Ritonavir		
	Nefazodone	Indinavir		
	Clarithromycin	Nelfinavir		
	Telithromycin	Atazanavir		
	Boceprevir	Fosamprenavir		
	Telaprevir	Lopinavir/Ritonavir		

References:
Relpax Prescribing Information, Jan. 2012, Pfizer US Pharmaceutical Group.
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.

40. Topiramate ER / Overutilization _____ _____

Alert Message: Trokendi XR (topiramate extended-release) may be over-utilized. The manufacturer's recommended maximum dose of extended-release topiramate is 400 mg once daily.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Topiramate XR		

Max Dose: 400mg/day

References:
Trokendi UX Prescribing Information, August 2013, Supernus Pharmaceuticals.

41. Topiramate IR / Migraine / Negating Seizures & Anticonvulsants _____ _____

Alert Message: The manufacturer's recommended maximum daily dose of topiramate as treatment for adults for prophylaxis of migraine headache is 100 mg per day in two divided doses.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Topiramate IR 100	Migraine	Seizures/Epilepsy
Topiramate IR 200		Anticonvulsants

References:
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.
Topamax Prescribing Information, Oct. 2012, Janssen Pharmaceuticals, Inc.