South Dakota Department of Social Services

Medicaid P&T Committee Meeting

March 20, 2015

DSS
Strong Families - South Dakota's Foundation and Our Future

DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES
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Pierre, South Dakota 57501-2291
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SOUTH DAKOTA
MEDICAID P&T COMMITTEE MEETING
AGENDA

Friday, March 20, 2015
1:00 – 3:00 PM

Location:
Ramada Sioux Falls Airport Hotel
1301 West Russell
Sioux Falls, SD

Call to order

Approval of minutes of previous meeting

Prior authorization update

Review of top 15 therapeutic categories/top 25 drugs

Old business
- **ADHD in adults**
- **Otezla prior authorization form**
- **GLP-1 receptor agonists form**
- **New topical therapies for onychomycosis form**
- **PA forms and criteria review**

New business
- **Review of Xtoro**
- **Review of Hemangeol**
- **Review of agents used to treat idiopathic pulmonary fibrosis (Ofev, Esbriet)**

Oral presentations and comments by manufacturers' representatives

Next meeting date/adjournment

Minutes of the December 12, 2014
Pharmacy & Therapeutics (P&T) Committee Meeting
South Dakota Department of Social Services, Division of Medical Services

Members present
Bill Ladwig, RPh; Dana Darger, RPh; James Engelbrecht, MD; Lenny Petrik; Deb Farver; Kelley Oehlke

DSS staff present
Mike Jockheck, RPh

Administrative business
The P&T meeting was called to order by D. Darger at 1:00pm. The minutes of the September 26, 2014 meeting were presented. D. Farver made a motion to approve. K. Oehlke seconded the motion. The motion was approved unanimously.

Prior authorization update and statistics
The committee reviewed the prior authorization (PA) activity for October 2014. There were a total of 3,409 PA's processed in the month of October, with 99.35% of those requests responded to in less than eight hours. There were 2,581 (76%) requests received electronically and 828 (24%) requests received by fax.

Analysis of the top 15 therapeutic classes
The committee reviewed the Top 15 therapeutic classes by total cost of claims from 07/1/2014 – 09/30/2014. The top five classes were antipsychotics, respiratory and CNS stimulants, central nervous system agents, misc., amphetamines, and insulins. The top 15 therapeutic classes make up 40.30% of total claims. The Committee also reviewed the top 25 drugs based on total claims cost and number of claims. The top 25 drugs by claims cost make up 9.38% of total claims.

Review of drug spend
The committee reviewed a table showing SD Medicaid drug spend from 2012 – 2014. The average cost per script rose from $64.45 in 2012 to $77.33 in 2014. The average recipient script cost rose from $172.76 in 2012 to $209.07 in 2014.

Patent expirations
The committee reviewed a list of medications with an upcoming anticipated availability of a first-time generic.

Hepatitis C update
The committee reviewed Harvoni, Solvadi, and Olysio PA forms with incorporated changes since the last meeting. Utilization for the new medications used to treat Hepatitis C was provided. Brent Hildebrand, representing Gilead spoke regarding Harvoni.

Stimulant use in adults
The committee reviewed stimulant use in adults at the September meeting. It was requested that a form be developed for stimulant use in adults. After reviewing the form provided, the committee recommended removing 'specialist involved in therapy' and adding a check box for concomitant benzos/opioids. A motion was made by J. Engelbrecht to make recommended changes to the ADHD for adults form. B. Ladwig seconded the motion. The updated form will be brought to the March meeting.

Evzio review
The committee reviewed the prior authorization form provided for Evzio. B. Ladwig made a motion to approve the form. D. Farver seconded the motion. The motion was approved unanimously.

Otezla review
The committee reviewed the prior authorization form provided for Otezla. J. Engelbrecht made a recommendation that 'specialist involved in therapy' be added as well as a request for patient's GFR. Kendig Bergstresser, representing Celgene, spoke regarding Otezla. J. Engelbrecht made a motion to make modifications to the form and table until March. D. Farver seconded the motion. The motion was approved unanimously. The Otezla form will be brought back to the March meeting.

High cost medications
The committee reviewed the prior authorization form for high cost medications. There was no public comment. B. Ladwig made a motion to approve the form. K. Oehlke seconded the motion. The motion was approved unanimously.

GLP-1 receptor agonists review
The committee reviewed GLP-1clinical information. There was no public comment. J. Engelbrecht made a motion to place GLP-1 receptor agonists on prior authorization. L. Petrick seconded the motion. The motion was approved unanimously. The prior authorization form for GLP-1 receptor agonists will be brought back to the March meeting.

New topical therapies for onychomycosis review
The committee reviewed topical therapies for onychomycosis clinical information. There was no public comment. J. Engelbrecht made a motion to place these agents on prior authorization. D. Farver seconded. A form will be brought back to the March meeting.

The next meeting is scheduled for March 20, 2015. B. Ladwig made a motion to adjourn the P&T Committee meeting. D. Farver seconded the motion. The motion passed unanimously and the meeting was adjourned.

South Dakota Medicaid
Monthly Prior Authorization Report
January 1, 2015 – January 31, 2015

Time Ratio

Total PAs	Response Under 8 Hours	Response Over 8 Hours	% Under 8 Hours	% Over 8 Hours
3,514	3,511	3	99.91%	0.09%

By Form Type

Form Type	Description	Approve	Deny
ADP	Antidepressant	168	260
AFX	Amrix and Fexmid	1	6
ALT	Altabax	0	1
AMB	Ambien CR	2	19
ANF	Anti-Infectives(anti-biotic)	0	70
ANT	Antihistamines	8	35
APS	Antipsychotic	309	443
ARB	ARBS	2	11
COA	Oral Anticoagulants	3	10
DAW	Dispense As Written	14	6
EME	Antiemetics	0	18
GRH	Growth Hormone	2	1
GSM	Genitourinary SMR	6	26
HEP	Hepatitis Meds	1	7
HLM	Head Lice Medication	12	63
LID	Lidoderm	0	136
MAX	Max Units Override	61	1200
NUC	Opioids	2	8
ONF	Onfi	5	0
OPH	Ophthalmic Antihistamines	0	18
PPI	Proton Pump Inhibitors	32	128
SAN	Sancuso	0	1
SMR	Skeletal Muscle Relaxants	0	27
STE	Nasal Steroids	9	67
STI	Stimulants	7	28
SUB	Suboxone/Subutex	5	15
TIM	Targeted Immune Modulators	6	7
TOP	Topical Acne Agents	9	130
TRP	Triptans	16	68
ULT	Ultram ER	3	8
XIF	Xifaxan	3	10
XOI	Xanthine Oxidase Inhibitor	1	0
Totals		687	2827

HEALTH INFORMATION DESIGNS

South Dakota Medicaid
Monthly Prior Authorization Report
January 1, 2015 – January 31, 2015

By Request Type

01/01/15 - 01/31/15	# of	Electronic Requests		Faxed Requests	
	Requests	#	%	#	%
Prior Authorizations:					
Antidepressant	428	317	74%	111	26%
Amrix and Fexmid	7	5	71%	2	29%
Altabax	1	1	100%	0	0%
Ambien CR	21	21	100%	0	0%
Anti-Infectives(anti-biotic)	70	69	99%	1	1%
Antihistamines	43	36	84%	7	16%
Antipsychotic	752	512	68%	240	32%
ARBS	13	12	92%	1	8%
Oral Anticoagulants	13	7	54%	6	46%
Dispense As Written	20	0	0%	20	100%
Antiemetics	18	18	100%	0	0%
Growth Hormone	3	0	0%	3	100%
Genitourinary SMR	32	23	72%	9	28%
Hepatitis Meds	8	0	0%	8	100%
Head Lice Medication	75	49	65%	26	35%
Lidoderm	136	119	88%	17	13%
Max Units Override	1261	1142	90%	119	10%
Opioids	10	7	70%	3	30%
Onfi	5	0	0%	5	100%
Ophthalmic Antihistamines	18	18	100%	0	0%
Proton Pump Inhibitors	160	129	81%	31	19%
Sancuso	1	1	100%	0	0%
Skeletal Muscle Relaxants	27	27	100%	0	0%
Nasal Steroids	76	62	82%	14	18%
Stimulants	35	23	66%	12	34%
Suboxone/Subutex	20	13	65%	7	35%
Targeted Immune Modulators	13	8	62%	5	38%
Topical Acne Agents	139	100	72%	39	28%
Triptans	84	62	74%	22	26%
Ultram ER	11	9	82%	2	18%
Xifaxan	13	9	69%	4	31%
Xanthine Oxidase Inhibitor	1	0	0%	1	100%
Prior Authorization Totals	3514	2799	80%	715	20%

South Dakota Medicaid
Monthly Prior Authorization Report
January 1, 2015 – January 31, 2015

Electronic PAs (unique)

01/01/15 - 01/31/15	# Unique Approved	# Unique Denied	# Unique Incomplete	Unique Total	Approval %	Total Transactions
Prior Authorizations:						
Antidepressant	103	208	0	311	33.10%	317
Amrix and Fexmid	0	5	0	5	0.00%	5
Altabax	0	1	0	1	0.00%	1
Ambien CR	2	8	0	10	20.00%	21
Anti-Infectives(anti-biotic)	0	68	0	68	0.00%	69
Antihistamines	4	32	0	36	11.10%	36
Antipsychotic	120	359	1	480	25.00%	512
ARBS	2	8	0	10	20.00%	12
Oral Anticoagulants	0	7	0	7	0.00%	7
Antiemetics	0	16	0	16	0.00%	18
Genitourinary SMR	3	19	0	22	13.60%	23
Head Lice Medication	0	47	0	47	0.00%	49
Lidoderm	0	102	0	102	0.00%	119
Max Units Override	10	1066	0	1076	0.90%	1116
Opioids	0	5	0	5	0.00%	7
Ophthalmic Antihistamines	0	18	0	18	0.00%	18
Proton Pump Inhibitors	14	111	0	125	11.20%	129
Sancuso	0	1	0	1	0.00%	1
Skeletal Muscle Relaxants	0	26	0	26	0.00%	27
Nasal Steroids	3	56	0	59	5.10%	62
Stimulants	2	19	0	21	9.50%	23
Suboxone/Subutex	0	13	0	13	0.00%	13
Targeted Immune Modulators	2	6	0	8	25.00%	8
Topical Acne Agents	1	98	0	99	1.00%	100
Triptans	7	50	0	57	12.30%	62
Ultram ER	2	6	0	8	25.00%	9
UNKNOWN(online)	0	21	0	21	0.00%	26
Xifaxan	0	7	0	7	0.00%	9
TOTALS	275	2383	1	2659	10.30%	2799

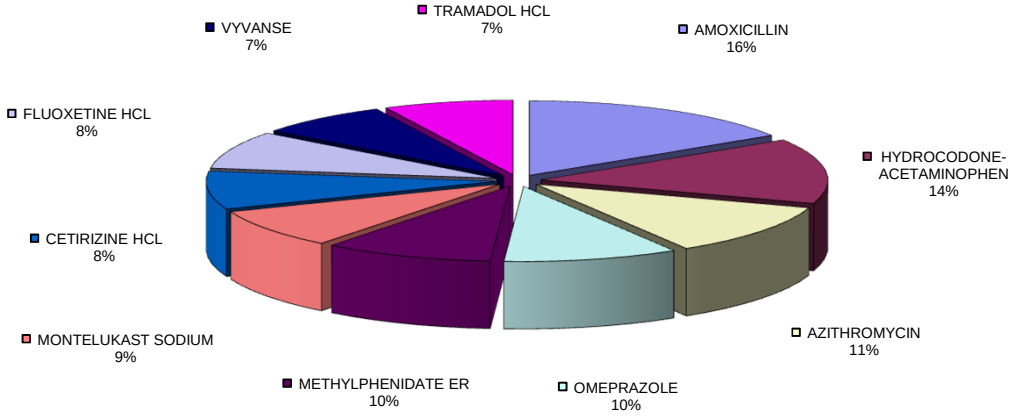
SOUTH DAKOTA MEDICAID
Cost Management Analysis

TOP 25 DRUGS BASED ON NUMBER OF CLAIMS FROM 10/01/2014 - 12/31/2014

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
AMOXICILLIN	PENICILLINS	6,567	$ 55,906.23	$ 8.51	3.20%
HYDROCODONE-ACETAMINOPHEN	OPIATE AGONISTS	5,805	$ 109,558.64	$ 18.87	2.83%
AZITHROMYCIN	MACROLIDES	4,611	$ 68,495.80	$ 14.85	2.24%
OMEPRAZOLE	PROTON-PUMP INHIBITORS	4,011	$ 46,873.00	$ 11.69	1.95%
METHYLPHENIDATE ER	RESPIRATORY AND CNS STIMULANTS	3,886	$ 579,152.17	$ 149.04	1.89%
MONTELUKAST SODIUM	LEUKOTRIENE MODIFIERS	3,459	$ 68,329.90	$ 19.75	1.68%
CETIRIZINE HCL	SECOND GENERATION ANTIHISTAMINES	3,378	$ 24,984.69	$ 7.40	1.64%
FLUOXETINE HCL	ANTIDEPRESSANTS	3,361	$ 28,043.91	$ 8.34	1.64%
VYVANSE	AMPHETAMINES	3,037	$ 574,993.34	$ 189.33	1.48%
TRAMADOL HCL	OPIATE AGONISTS	2,980	$ 23,607.22	$ 7.92	1.45%
LEVOTHYROXINE SODIUM	THYROID AGENTS	2,861	$ 37,055.53	$ 12.95	1.39%
SERTRALINE HCL	ANTIDEPRESSANTS	2,836	$ 20,947.66	$ 7.39	1.38%
ALBUTEROL SULFATE	BETA-ADRENERGIC AGONISTS	2,647	$ 47,239.18	$ 17.85	1.29%
TRAZODONE HCL	ANTIDEPRESSANTS	2,369	$ 14,329.90	$ 6.05	1.15%
DEXTROAMPHETAMINE-AMPHET ER	AMPHETAMINES	2,224	$ 278,156.99	$ 125.07	1.08%
LISINOPRIL	ANGIOTENSIN-CONVERTING ENZYME INHIBITORS	2,203	$ 12,120.71	$ 5.50	1.07%
LORATADINE	SECOND GENERATION ANTIHISTAMINES	2,139	$ 12,213.46	$ 5.71	1.04%
VENTOLIN HFA	BETA-ADRENERGIC AGONISTS	2,076	$ 99,530.45	$ 47.94	1.01%
GABAPENTIN	ANTICONVULSANTS, MISCELLANEOUS	1,978	$ 33,191.57	$ 16.78	0.96%
INTUNIV	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	1,930	$ 536,943.65	$ 278.21	0.94%
CLONIDINE HCL	CENTRAL ALPHA-AGONISTS	1,864	$ 12,945.95	$ 6.95	0.91%
CLONAZEPAM	BENZODIAZEPINES (ANTICONVULSANTS)	1,806	$ 14,127.14	$ 7.82	0.88%
FLUTICASONE PROPIONATE	CORTICOSTEROIDS (EENT)	1,781	$ 26,596.68	$ 14.93	0.87%
AMOX TR-POTASSIUM CLAVULANATE	PENICILLINS	1,719	$ 44,596.56	$ 25.94	0.84%
SULFAMETHOXAZOLE-TRIMETHOPRIM	SULFONAMIDES (SYSTEMIC)	1,709	$ 42,051.47	$ 24.61	0.83%
TOTAL TOP 25		73,237	$ 2,811,991.80	$ 38.40	35.65%

Total Rx Claims From 10/01/2014 - 12/31/2014	205,436

Top 10 Drugs
Based on Number of Claims



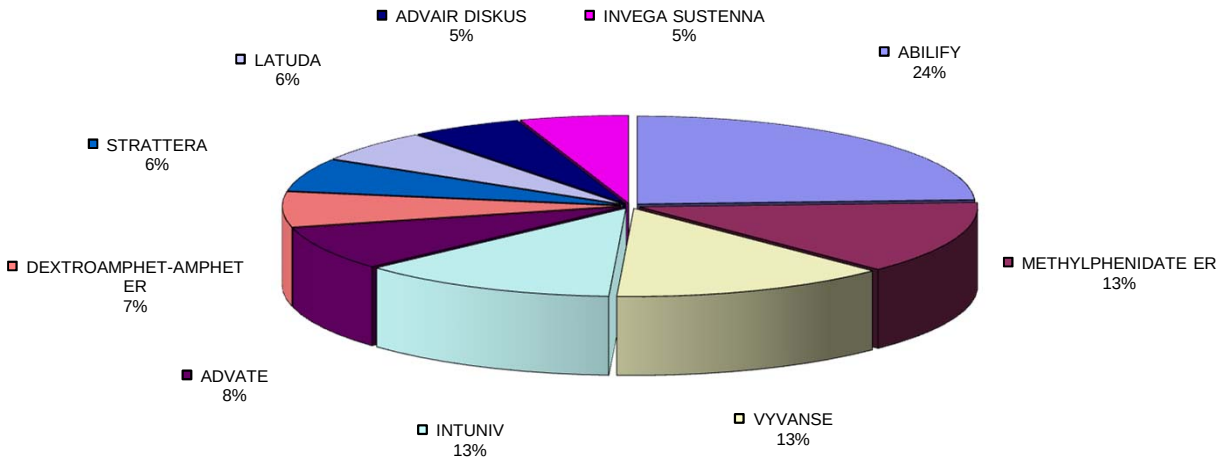
SOUTH DAKOTA MEDICAID
Cost Management Analysis

TOP 25 DRUGS BASED ON TOTAL CLAIMS COST FROM 10/01/2014 - 12/31/2014

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
ABILIFY	ANTIPSYCHOTIC AGENTS	1,478	$1,051,445.15	$ 711.40	0.72%
METHYLPHENIDATE ER	RESPIRATORY AND CNS STIMULANTS	3,886	$ 579,152.17	$ 149.04	1.89%
VYVANSE	AMPHETAMINES	3,037	$ 574,993.34	$ 189.33	1.48%
INTUNIV	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	1,930	$ 536,943.65	$ 278.21	0.94%
ADVATE	HEMOSTATICS	8	$ 346,825.42	$ 43,353.18	0.00%
DEXTROAMPHET-AMPHET ER	AMPHETAMINES	2,224	$ 278,156.99	$ 125.07	1.08%
STRATTERA	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	965	$ 261,386.44	$ 270.87	0.47%
LATUDA	ANTIPSYCHOTIC AGENTS	359	$ 254,967.96	$ 710.22	0.17%
ADVAIR DISKUS	CORTICOSTEROIDS (RESPIRATORY TRACT)	778	$ 231,603.75	$ 297.69	0.38%
INVEGA SUSTENNA	ANTIPSYCHOTIC AGENTS	153	$ 225,615.80	$ 1,474.61	0.07%
LYRICA	ANTICONVULSANTS, MISCELLANEOUS	710	$ 224,808.25	$ 316.63	0.35%
FOCALIN XR	RESPIRATORY AND CNS STIMULANTS	891	$ 216,516.72	$ 243.00	0.43%
HUMIRA	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	70	$ 216,032.48	$ 3,086.18	0.03%
LANTUS SOLOSTAR	INSULINS	512	$ 197,239.50	$ 385.23	0.25%
PULMOZYME	MUCOLYTIC AGENTS	66	$ 186,762.81	$ 2,829.74	0.03%
PREVACID	PROTON-PUMP INHIBITORS	551	$ 178,500.58	$ 323.96	0.27%
COPAXONE	IMMUNOMODULATORY AGENTS	32	$ 166,853.27	$ 5,214.16	0.02%
ENBREL	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	59	$ 162,995.52	$ 2,762.64	0.03%
FLOVENT HFA	CORTICOSTEROIDS (RESPIRATORY TRACT)	890	$ 161,650.80	$ 181.63	0.43%
HELIXATE FS	HEMOSTATICS	3	$ 158,283.33	$ 52,761.11	0.00%
NOVOLOG FLEXPEN	INSULINS	365	$ 157,242.61	$ 430.80	0.18%
OXYCONTIN	OPIATE AGONISTS	445	$ 147,257.51	$ 330.92	0.22%
NOVOLOG	INSULINS	381	$ 140,009.65	$ 367.48	0.19%
XENAZINE	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	15	$ 128,885.12	$ 8,592.34	0.01%
NEXIUM	PROTON-PUMP INHIBITORS	447	$ 122,484.23	$ 274.01	0.22%
TOTAL TOP 25		20,255	$ 6,906,613.05	$ 340.98	9.86%

Total Rx Claims From 10/01/2014 - 12/31/2014	205,436

Top 10 Drugs
Based on Total Claims Cost



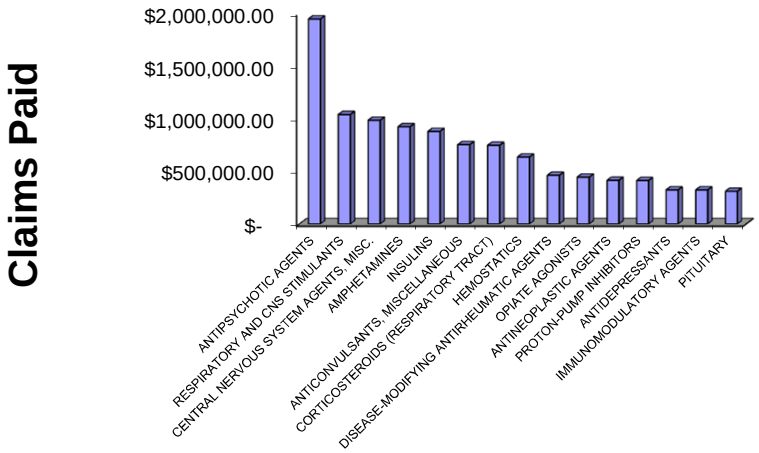
SOUTH DAKOTA MEDICAID
Cost Management Analysis

TOP 15 THERAPEUTIC CLASSES BY TOTAL COST OF CLAIMS FROM 10/01/2014 - 12/31/2014

AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
ANTIPSYCHOTIC AGENTS	6,786	$ 1,943,621.49	$ 286.42	3.30%
RESPIRATORY AND CNS STIMULANTS	6,946	$ 1,039,885.68	$ 149.71	3.38%
CENTRAL NERVOUS SYSTEM AGENTS, MISC.	3,155	$ 985,845.47	$ 312.47	1.54%
AMPHETAMINES	6,236	$ 924,233.88	$ 148.21	3.04%
INSULINS	2,344	$ 879,106.06	$ 375.05	1.14%
ANTICONVULSANTS, MISCELLANEOUS	9,234	$ 753,394.32	$ 81.59	4.49%
CORTICOSTEROIDS (RESPIRATORY TRACT)	3,051	$ 747,088.15	$ 244.87	1.49%
HEMOSTATICS	29	$ 636,276.35	$ 21,940.56	0.01%
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	180	$ 462,460.91	$ 2,569.23	0.09%
OPIATE AGONISTS	13,386	$ 444,994.58	$ 33.24	6.52%
ANTINEOPLASTIC AGENTS	511	$ 414,590.66	$ 811.33	0.25%
PROTON-PUMP INHIBITORS	6,292	$ 412,500.95	$ 65.56	3.06%
ANTIDEPRESSANTS	17,907	$ 324,443.14	$ 18.12	8.72%
IMMUNOMODULATORY AGENTS	62	$ 324,041.17	$ 5,226.47	0.03%
PITUITARY	575	$ 310,263.57	$ 539.59	0.28%
TOTAL TOP 15	76,694	$ 10,602,746.38	$ 138.25	37.33%

Total Rx Claims From 10/01/2014 - 12/31/2014	205,436

Top 15 Therapeutic Classes
Based on Total Cost of Claims



ADULT ADD/ADHD
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that adult patients receiving a new prescription for ADHD therapies must meet the following criteria:

- Patient must be 18 years of age or older and have a documented diagnosis of adult ADD or ADHD
- Patient was diagnosed before the age of 16 and continues to have significant symptoms warranting treatment in adulthood

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug:	Diagnosis for this Request:	Was the diagnosis before age 16:

List symptoms significantly impacting, impairing, or compromising the patient's ability to function normally:

Concomitant benzodiazepines:	Concomitant opioids:
□ YES □ NO	□ YES □ NO

PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

Date: / / Initials: _____

Approved -
Effective dates of PA: From: / / To: / /

Denied: (Reasons)

OTEZLA
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that adult patients receiving a new prescription for Otezla must meet the following criteria:

- Patient must be 18 years of age or older and have a documented diagnosis of active psoriatic arthritis or moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy.
- Must not use Otezla in combination with Enbrel, Humira, Cimzia, Orencia, Kineret, Simponi, or Remicade.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	SPECIALIST INVOLVED IN THERAPY:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug:	Diagnosis for this Request:
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONISTS (GLP-1 AGONISTS) PRIOR AUTHORIZATION

SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that adult patients receiving a new prescription for GLP-1 Agonists must meet the following criteria:

- Patient must have a diagnosis of Type 2 diabetes mellitus.
- Trial of metformin or a sulfonylurea.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug: □ BYDUREON □ TANZEUM □ BYETTA □ TRULICITY □ VICTOZA	Diagnosis for this Request:

Qualifications for coverage:

1. Trial of metformin or a sulfonylurea. □ Yes □ No
2. Impaired renal function or history of lactic acidosis that prevents treatment with metformin. □ Yes □ No
3. Contraindication to both metformin and sulfonylurea. □ Yes □ No

PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

Date: / / Initials: _____

Approved -
Effective dates of PA: From: / / To: / /

Denied: (Reasons)

TOPICAL AGENTS FOR ONYCHOMYCOSIS
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that adult patients receiving a new prescription for topical onychomycosis therapies must meet the following criteria:

- Patient must have a diagnosis of onychomycosis of the toenails.
- Patient must try and fail terbinafine tablets and topical ciclopirox.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug:	Diagnosis for this Request:	
Trial of terbinafine tablets: □ YES □ NO	Trial of topical ciclopirox: □ YES □ NO	
PHYSICIAN SIGNATURE:	DATE:	

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

PRIOR AUTHORIZATION REQUEST FORM
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

ADULT GROWTH HORMONE

Please fill out form completely

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
RECIPIENT DOB:	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
Is prescribing physician board certified endocrinologist or gastroenterologist ? ☐ YES ☐ NO	PHONE:	FAX:

Part III: TO BE COMPLETED BY PHYSICIAN:

REQUESTED DRUG:	**Requested Dosage:** (must be completed)
☐ INITIAL REQUEST ☐ RENEWAL REQUEST	**Diagnosis for this request:**

QUALIFICATIONS FOR COVERAGE:

Does patient have a diagnosis of: ☐ Panhypopituitarism **OR** ☐ Prader-Willi Syndrome (If either, may skip questions 1, 2, & 3)

1. IGF-1 Level:

2. Provocative testing:

Type_____Results_____Date_____

Type_____Results_____Date_____

3. Has the patient been screened for intracranial malignancy or tumor? ☐ YES ☐ NO

4. Does the patient have any of the following contraindications? Check all that apply.
☐ Proliferative Diabetic retinopathy ☐ Benign intracranial hypertension ☐ NONE

Physician signature:	Date:

Part IV: PHARMACY INFORMATION

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

ALTABAX PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a prescription for Altabax must first try and fail MUPIROCIN.

- **Patients must use generic mupirocin for a minimum of 5 days for the trial to be considered a failure.**
- **Patients diagnosed with MRSA may be approved to use Altabax first-line.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:			PHYSICIAN PROVIDER NUMBER:
City:	State:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Dosage: (must be completed)	**Diagnosis for this request:**
Qualifications for coverage:	
❑ Failed trial of mupirocin in the last 90 days	Was mupirocin trial for at least 5 days? ❑ YES ❑ NO
Adverse Reaction (attach FDA Medwatch form) or contraindication to mupirocin: (provide description below):	
Medical Justification for use of Altabax without trial of mupirocin:	
Physician Signature:	Date:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

AMBIEN CR PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients have a trial of zolpidem prior to receiving a PA for Ambien CR.

- **Patients must use generic zolpidem for a minimum of 14 days for the trial to be considered a failure.**
- **Previous usage of Ambien CR does not count as a trial.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
City:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Dosage: (must be completed)

Diagnosis for this request:

Qualifications for coverage:

❑ Failed trial of zolpidem in the last 365 days	Was zolpidem trial for at least 14 days? ❑ YES ❑ NO	Zolpidem Dose:
		Zolpidem Frequency:

Adverse Reaction (attach FDA Medwatch form) or contraindication to zolpidem: (provide description below):

Medical Justification for use of Ambien CR without trial of zolpidem:

Physician Signature: Date:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

AMPYRA
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Ampyra must meet the following criteria:

- **Patient must have a confirmed diagnosis of multiple sclerosis.**
- **Patient must be 18 years or older.**
- **Patient must have a physiatrist/neurologist involved in therapy.**
- **Patient must not have a history of seizures.**
- **Patient does not have moderate to severe renal impairment (CrCl less than 50mL/min).**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	PHYSIATRIST/NEUROLOGIST INVOLVED IN THERAPY
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ AMPYRA _____	Diagnosis 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
PHYSICIAN SIGNATURE:		DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

AMRIX/FEXMID PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients have a trial of cyclobenzaprine before receiving a PA for Amrix or Fexmid.

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

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
City:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Medication Requested: □ **AMRIX** □ **FEXMID**	**Requested Dosage:** (must be completed) **Diagnosis for this request:**

Qualifications for coverage:

❑ Failed cyclobenzaprine therapy	Start Date: Dose: End Date: Frequency:

Adverse Reaction (attach FDA MedWatch form) or contraindication to inactive ingredients in cyclobenzaprine: (provide description below):

Medical Justification for use of Amrix or Fexmid without trial of cyclobenzaprine:

Physician Signature: Date:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

ANTIDEPRESSANT PRIOR AUTHORIZATION FORM

SD DEPARTMENT OF SOCIAL SERVICES MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for a second tier antidepressant must fail a first tier agent.

- Tricyclics, trazodone, bupropion, citalopram, fluoxetine, mirtazapine, immediate release paroxetine, sertraline and venlafaxine do not require a prior authorization.
- Patients currently stabilized on a second generation antidepressant will not be asked to change medication.
- Escitalopram will not require a prior authorization for recipients under the age of 18.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
City:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: (must be completed)

Diagnosis for this request:

Qualifications for coverage:

☐ One failed trial with an antidepressant from tier one.

1. List failed medication

Adverse Reaction (attach FDA MedWatch form) or contraindication: (provide description below):

Medical Justification for use of a tier two agent without trial of a tier one agent:

Physician Signature: Date:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

SANCUSO/GRANISOL/ZUPLENZ
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Sancuso, Granisol or Zuplenz must first try other anti-nausea medications.

- **Patients must use a generic 5-hydroxytryptamine-3 receptor antagonist or other anti-nausea medication for at least 14 days for the trial to be considered a failure.**
- **Patients must be receiving moderately and/or highly emetogenic chemotherapy for up to 5 consecutive days.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Sancuso _____ □ Granisol _____ □ Zuplenz _____	Patient able to tolerate oral medications: Failed medication _____ Was trial for at least 14 days? □ YES □ NO
□ Patient unable to tolerate oral medications (Sancuso only)	
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

ATYPICAL ANTIPSYCHOTICS (Second Generation) PRIOR AUTHORIZATION FORM

SD DEPARTMENT OF SOCIAL SERVICES MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for an atypical antipsychotic (second generation) must have an included indication:

- Traditional antipsychotics (first generation) do not require a prior authorization.
- Children less than 6 years of age must have a psychiatrist, developmental pediatrician, child/adolescent psychiatrist or pediatric neurologist involved in care.
- Two concomitant atypical antipsychotics must involve psychiatrist or mid-level practitioner in collaboration with a psychiatrist.
- If the antipsychotic is prescribed for depression, the recipient must try and fail two antidepressant classes.
- Patients currently stabilized on an atypical antipsychotic (second generation) will not be asked to change medication.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
City:	PHONE: ( )	FAX: ( )
Two concomitant antipsychotics: Recipient under the care of psychiatrist or mid-level practitioner in collaboration with a psychiatrist? ▫ Yes (please include prescriber's information) ▫ No **90 day transition period will be allowed*		Children less than 6 years of age: Does recipient have a psychiatrist, developmental pediatrician, child/adolescent psychiatrist or pediatric neurologist involved in care? ▫ Yes (please include prescriber's information) ▫ No

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: (must be completed)	
Diagnosis for this request:	**Depression-list two antidepressant class failures**
Qualifications for coverage of alternate dosage forms/isomers/metabolites:	
☐ Unable to swallow the standard tablet/capsule dosage form	☐ Currently being discharged from an inpatient mental health facility
Adverse Reaction (attach FDA MedWatch form) or contraindication: (provide description below):	
Medical Justification for use of alternate dosage forms or isomers/metabolites of a covered agent without trial of a tier one agent:	
Physician Signature:	**Date:**

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

ANTI-HISTAMINE PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving anti-histamines must use **Loratadine*** as first line.

- **Loratadine OTC and cetirizine may be prescribed WITHOUT prior authorization. Loratadine and cetirizine are covered by Medicaid when prescribed by a physician.**
- **Prior authorization is NOT required for patients < 13 years of age.**
- **Patients must use loratadine and cetirizine for a minimum of 14 days for the trial to be considered a failure. Patient preference does not constitute failure.**
- **Patients are encouraged to try and fail generic loratadine and cetirizine prior to receiving a leukotriene modifier or intranasal steroid to treat allergic rhinitis.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

REQUESTED DRUG (PLEASE CHECK)**:** ❑ Allegra ❑ Allegra-D ❑ Claritin Rx ❑ Clarinex ❑ Clarinex –D ❑ Claritin-D Rx ❑ Zyrtec ❑ Zyrtec-D ❑ Fexofenadine ❑ Xyzal	**Requested Dosage:** (must be completed) **Diagnosis for this request:**

Qualifications for coverage:

❑ Failed loratadine ❑ Failed cetirizine	Was trial for at least 14 days? ❑ YES ❑ NO	Dose: Frequency:

Adverse Reaction (attach FDA Medwatch form) to loratadine or cetirizine or contraindicated: (provide description below)

Physician Signature: Date:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

ARB PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving an ARB first try and fail one ACE Inhibitor. A PA may be given for one of the following reasons:

- **The patient has been stable on an ARB for greater than 60 days**
- **Patient has an additional diagnosis (such as COPD or RF) that precludes a trial with an ACE Inhibitor**
- **The provider has additional medical justification that supports first-line therapy with an ARB**

ARBs include: Atacand, Avapro, Avalide, Azor, Benicar, Diovan, Edarbi, Exforge, Hyzaar, Micardis, Teveten, Tribenzor, Twynsta, Valturna.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy)

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy)

PHYSICIAN NAME:		PHYSICIAN MEDICAID ID NUMBER:
City:	FAX: ( )	Phone: ( )

Part III: TO BE COMPLETED BY PHYSICIAN

REQUESTED DRUG:	**Requested Dosage:** (must be completed)
	Diagnosis for this request:

Qualifications for coverage:

Has patient been stable on requested ARB for more than 60 days? ❑ YES ❑ NO

Has patient tried and failed an ACE Inhibitor? ❑ YES ❑ NO

Does patient have a diagnosis of COPD or acute/chronic renal failure? ❑ YES ❑ NO

Medical Justification for use of an ARB without a trial of an ACEI:

Physician Signature: Date:

Part IV: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

AUBAGIO
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Aubagio must meet the following criteria:

- Patient must have a confirmed diagnosis of a relapsing form of multiple sclerosis.
- Patient must have a neurologist involved in therapy.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	NEUROLOGIST INVOLVED IN THERAPY:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ **Aubagio**	Diagnosis for this request:
PHYSICIAN SIGNATURE: DATE:	

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

CALOMIST/NASCOBAL
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for CaloMist or Nascobal must try injectable B-12 as first line therapy.

- **Injectable B-12 does not require a prior authorization.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage:			Diagnosis for this request:	
□ Failed Therapy	Dose	Frequency	Start Date	End Date
□ Medical Justification for use of CaloMist or Nascobal without a trial of injectable B-12:				
PHYSICIAN SIGNATURE:				DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

DISPENSE AS WRITTEN PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving brand name medications (with a generic available) first try and fail the generic product. A PA may be given for one the following reasons:

- **The generic product was not effective**
- **There was an adverse reaction with the generic product**
- **The generic product is not available**

If a drug is on the South Dakota Narrow Therapeutic Index list, the drug is excluded from the PA requirement

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy)

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy)

PHYSICIAN NAME:		PHYSICIAN MEDICAID ID NUMBER:
City:	FAX: ( )	Phone: ( )

Part III: TO BE COMPLETED BY PHYSICIAN

REQUESTED BRAND NAME DRUG:	**Requested Dosage:** (must be completed)
	Diagnosis for this request:

Qualifications for coverage:

Has treatment with the generic equivalent been attempted? ❑ YES ❑ NO

If yes, please indicate the reason for discontinuation below.

❑ Adverse reaction to the generic equivalent (FDA Medwatch form is required – form is available at www.fda.gov or www.hidsdmedicaid.com)

❑ Contraindication of generic equivalent (please provide medical justification in this space):

Physician Signature: Date:

Part IV: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

DESOXYN PA FORM
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Desoxyn must meet the following criteria:

- **Patient must be over 6 years of age.**
- **Diagnosis of Attention Deficit Disorder with Hyperactivity. (Desoxyn is not covered for the treatment of obesity)**
- **Four documented trials of the following options: a long-acting amphetamine salts product; a long-acting methylphenidate product; a long-acting product with a short-acting product; guanfacine; and atomoxetine.**
- **Trials within the last 90 days**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy)

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy)

PHYSICIAN NAME:	PHYSICIAN MEDICAID ID NUMBER:	
City:	FAX: ( )	Phone: ( )

Part III: TO BE COMPLETED BY PHYSICIAN

REQUESTED DRUG:	**Requested Dosage:** (must be completed)
	Diagnosis for this request:

Qualifications for coverage:

	Drug Name/s	Start Date	End Date	Dose	Frequency
□ long-acting amphetamine salts					
□ long-acting methylphenidate					
□ long-acting product with a short-acting product					
□ guanfacine					
□ atomoxetine					

Physician Signature:	Date:

Part IV: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( )	FAX: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

DICLEGIS
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Diclegis must meet the following criteria:

- Patient must have diagnosis of nausea and vomiting of pregnancy.
- Patient must try ondansetron for 7 days.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ **Diclegis**	Diagnosis for this request: Failed therapy (Drug and Dose) Start Date: End Date:
PHYSICIAN SIGNATURE: DATE:	

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

DIFICID
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD 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: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Dificid	Diagnosis for this request:
Failed therapy:	Dosage:
	Frequency:
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

EXTAVIA
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Extavia must meet the following criteria:

- **Patient must have a confirmed diagnosis of relapsing remitting multiple sclerosis.**
- **Patient must have a neurologist involved in therapy.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER	NEUROLOGIST INVOLVED IN THERAPY:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Extavia	Diagnosis for this request:
Medication failed □ Betaseron	**Start Date:** **End Date:**
Please provide clinical rationale as to why Extavia should be used given Betaseron failure or intolerance. Please note: Betaseron and Extavia are both Interferon β-1b.	
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

PRIOR AUTHORIZATION REQUEST FORM
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

☐ Antihistamines
☐ Proton Pump Inhibitors
☐ DAW Request
☐ Maximum Units Request
☐ Altabax
☐ Lindane/Malathion
☐ Ambien CR
☐ Ultram ER/Ryzolt
☐ ARBs
☐ Growth Hormone
☐ Vusion
☐ Xolair
☐ Other
☐ Amrix
☐ Fexmid
☐ Moxatag

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
RECIPIENT DOB:	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE:	FAX:

Part III: TO BE COMPLETED BY PHYSICIAN:

REQUESTED DRUG:	**Requested Dosage:** (must be completed)
	Diagnosis for this request:

QUALIFICATIONS FOR COVERAGE (Please include any additional relevant information):

Prior Therapies:
Medical Justification:
Adverse Reaction (attach FDA Medwatch form)or contraindication to drug requested: (please provide description below)

Physician signature:	Date:

Part IV: PHARMACY INFORMATION

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

Genitourinary Smooth Muscle Relaxants (GSM)
PRIOR AUTHORIZATION

SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for a GSM must meet the following criteria:

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

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage:	Diagnosis for this request:
□ **Enablex** □ **Detrol LA** □ **Toviaz** □ **Gelnique** □ **Myrbetriq** □ **Oxytrol** □ **Detrol** □ **Sanctura** □ **Vesicare** □ **Sanctura XR**	Failed therapy (Drug and Dose) Start Date: End Date:
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

GILENYA
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Gilenya must meet the following criteria:

- **Patient must have a confirmed diagnosis of relapsing multiple sclerosis.**
- **Patient must have a neurologist involved in therapy.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	NEUROLOGIST INVOLVED IN THERAPY:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Gilenya _____	Diagnosis for this request:
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

GRALISE
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD 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 and fail a 3 month course of gabapentin**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Gralise	Diagnosis for this request:
Failed therapy:	Dosage:
	Frequency:
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

HARVONI
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Harvoni must meet the following criteria:

- Patient must be ≥ 18 years old.
- Must have a diagnosis of chronic hepatitis C (genotype 1).
- Liver biopsy confirming a Metavir score of F3 or F4, unless medically contraindicated; or documentation of severe extrahepatic manifestations of hepatitis C infection.
- Must be prescribed by a hepatologist, gastroenterologist, or infectious disease specialist.
- Absence of renal impairment (eGFR must be >30mL/min/1.73m^2) and absence of end stage renal disease (ESRD).
- Documentation showing that patient is drug and alcohol free for the past 6 months.
- The concomitant use of Harvoni and P-gp inducers (rifampin, St. John's wort), certain anticonvulsants, certain antiretrovirals, and rosuvastatin is not recommended.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH:

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	NAME OF SPECIALIST:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug:	Diagnosis for this request:	Documented liver fibrosis:	Patient is drug and alcohol free for past 6 months:
□ **Harvoni** Dosage: _____	Genotype:	□ YES □ NO	□ YES □ NO eGFR:

Has the patient been previously treated for chronic hepatitis C? □ YES □ NO If yes, please indicate past treatment regimen(s), dates of treatment, and response to therapy:	Baseline HCV RNA: HCV RNA 4 weeks after starting therapy:
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX: ( )
DRUG:	NDC#

Part V: FOR OFFICIAL USE ONLY

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

HEAD LICE MEDICATION PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a prescription for lindane or malathion must use Rid® or Nix® first line.

- **Rid or Nix may be prescribed WITHOUT a prior authorization**
- **For a trial to be considered a failure, patients must use Rid or Nix as directed, including retreatment within 7-10 days after the first treatment.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:			PHYSICIAN PROVIDER NUMBER:
City:	State:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: (must be completed)	**Diagnosis for this request:**
Qualifications for coverage:	
❑ Failed trial of Rid or Nix in the last 30 days.	Did trial include retreatment within 7-10 days after the first treatment? ❑ YES ❑ NO
Adverse Reaction (attach FDA MedWatch form) or contraindication: (provide description below):	
Medical Justification for use of lindane or malathion without trial of Nix:	
Physician Signature:	Date:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

Hepatitis C Virus (HCV) Medication
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Incivek or Victrelis must have an FDA approved indication.

- Incivek and Victrelis patients must have a diagnosis of hepatitis C genotype 1.
- Incivek and Victrelis patients must be 18 years of age or older.
- Incivek and Victrelis patients must also be taking ribavirin and peg-interferon.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ **Incivek** □ **Victrelis**	Diagnosis for this request:	Genotype:
	Ribavirin dose: Peg-interferon dose:	
PHYSICIAN SIGNATURE: DATE:		

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

HORIZANT
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Horizant must have a diagnosis of restless leg syndrome.

- **Gabapentin and benzodiazepines do not require a prior authorization.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Horizant	Diagnosis for this request:
Failed therapy:	Dosage:
	Frequency:
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

LIDODERM
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Lidoderm must meet the following criteria:

- **Patient must have a diagnosis of post-herpetic neuralgia.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Lidoderm	Diagnosis for this request:
Dosing Instructions:	
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

TARGETED IMMUNE MODULATORS
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Orencia, Humira, Enbrel, Amevive, Kineret, Cimzia, Remicade, Actemra, Stelara and Simponi 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.**
- **Physician administered medications do not require a prior authorization**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage:	**FDA approved indication for this request:**
□ **Orencia** _____	□ **Adult Rheumatoid Arthritis**
□ **Amevive** _____	□ **Juvenile Idiopathic Arthritis**
□ **Enbrel** _____	□ **Plaque Psoriasis**
□ **Kineret** _____	□ **Ankylosing Spondylitis**
□ **Humira** _____	□ **Psoriatic Arthritis**
□ **Cimzia** _____	□ **Crohn's Disease**
□ **Remicade** _____	□ **Ulcerative Colitis**
□ **Simponi** _____	**Subspecialist Involved in Therapy:**
□ **Actemra** _____	
□ **Stelara** _____	
□ **Other** _____	

PHYSICIAN SIGNATURE: DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

MAXIMUM UNITS OVERRIDE REQUEST
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

- **SD Medicaid requires that patients exceeding the maximum recommended quantity/month submit an override request and provide medical justification for exceeding the maximum units.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy)

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy)

PHYSICIAN NAME:		PHYSICIAN MEDICAID ID NUMBER:
City:	FAX: ( )	Phone: ( )

Part III: TO BE COMPLETED BY PHYSICIAN

REQUESTED BRAND NAME DRUG:	**Requested Dosage:** (must be completed)
	Diagnosis for this request:

Qualifications for coverage:

Medical Justification (please include previous and current dosage):

Physician Signature: Date:

Part IV: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

METOZOLV ODT PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Metozolv must meet the following criteria:

- **Patient must try metoclopramide.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN MEDICAID PROVIDER NUMBER:
PHYSICIAN ADDRESS:		
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug: (must be completed) **Diagnosis for this request:**			
Qualifications for coverage:			
❑ Failed metoclopramide therapy	Start Date:	End Date:	Dose:
Physician Signature:			Date:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAIDPROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

MOXATAG PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients have a trial of amoxicillin before receiving a PA for Moxatag.

- **Amoxicillin does not require a PA**
- **Patient must fail therapy on generic amoxicillin before a PA will be considered.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
City:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Medication Requested: □ **MOXATAG**	**Requested Dosage:** (must be completed) **Diagnosis for this request:**

Qualifications for coverage:

❑ Failed amoxicillin	Start Date:	Dose:
	End Date:	Frequency:

Adverse Reaction (attach FDA MedWatch form) or contraindication to inactive ingredients in amoxicillin: (provide description below):

Medical Justification for use of Moxatag without trial of amoxicillin:

Physician Signature: Date:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

BRAND-NAME NARCOTICS PA FORM
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD 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 at a dose equivalent to the brand-name narcotic being prescribed.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN MEDICAID PROVIDER NUMBER:
PHYSICIAN ADDRESS:		
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug: (must be completed)

□ EMBEDA □ HYSINGLA □ FENTORA □ BUTRANS □ ABSTRAL □ ONSOLIS □ LAZANDA □ SUBSYS □ ZOHYDRO

Qualifications for coverage:

❑ Failed therapy	Start Date:	End Date:	Dose:	Frequency:

Physician Signature:	Date:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAIDPROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

NASAL STEROIDS
for Allergic Rhinitis
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for a nasal steroid for allergic rhinitis must meet the following criteria:

- Patient must first try a generic nasal steroid.
- Fluticasone and triamcinolone do not require a prior authorization.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ **Qnasl** □ **Rhinocort** □ **Omnaris** □ **Zetonna** □ **Dymista** □ **Nasonex** □ **Veramyst**	Diagnosis for this request:
PHYSICIAN SIGNATURE: DATE:	

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

NEXICLON
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Nexiclon must first try clonidine.

- **Clonidine does not require a prior authorization.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Nexiclon	Diagnosis for this request:
Failed therapy:	Dosage:
	Frequency:
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

NOVANTRONE
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Novantrone must meet the following criteria:

- **Patient must have one of the following confirmed diagnoses: secondary progressive multiple sclerosis, progressive relapsing multiple sclerosis, or worsening relapsing-remitting multiple sclerosis.**
- **Patient must have a neurologist involved in therapy.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	NEUROLOGIST INVOLVED IN THERAPY:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Novantrone	Diagnosis for this request:
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

NUCYNTA
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Nucynta must try an immediate release schedule-II opioid as first line therapy.

- **Nucynta should only be used as a second line agent for opioid naïve patients following failure with other immediate release schedule-II opioids.**
- **Immediate release oxycodone, oxymorphone, hydromorphone, and meperidine do not require a prior authorization.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage:			Diagnosis for this request:	
□ Failed Therapy	Dose	Frequency	Start Date	End Date
PHYSICIAN SIGNATURE:				DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

PRIOR AUTHORIZATION REQUEST FORM
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

PEDIATRIC GROWTH HORMONE

Please fill out form completely (Note: if this is a renewal request, please include height chart and documentation regarding efficacy with the request)

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
RECIPIENT DOB:	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
Is prescribing physician board certified endocrinologist or nephrologist? ☐ YES ☐ NO	PHONE:	FAX:

Part III: TO BE COMPLETED BY PHYSICIAN:

REQUESTED DRUG:	**Requested Dosage:** (must be completed)
☐ INITIAL REQUEST ☐ RENEWAL REQUEST	**Diagnosis for this request:**

QUALIFICATIONS FOR COVERAGE:
(Renewal requests do NOT need to answer the questions below, please submit height chart and documentation of efficacy):

For Growth Hormone Deficiency (please submit either IGF-1 level OR provocative testing results):

IGF-1 Level:_____

Provocative testing: Type_____Results_____Date_____

Has the patient been screened for intracranial malignancy or tumor? ☐ YES ☐ NO

For GHD AND Chronic Renal Insufficiency:
Is the patient's height value or growth velocity less than 2 standard deviations below the mean for age and/or Tanner Stage?
☐ YES ☐ NO

For Idiopathic Short Stature and SGA:
Please indicate patients height or include chart documentation:

Please indicate patient's predicted height:

For All Patients:
Does the patient have any of the following contraindications? Check all that apply.

☐ Benign intracranial hypertension ☐ Closed epiphyses ☐ NONE

Physician signature:	Date:

Part IV: PHARMACY INFORMATION

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

PROTON PUMP INHIBITOR PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving proton pump inhibitors use **omeprazole, pantoprazole or lansoprazole** first line.

- **Omeprazole, pantoprazole or lansoprazole may be prescribed WITHOUT prior authorization.**
- **Prior authorization is NOT required for patients < 13 years of age**
- **Patients must use omeprazole, pantoprazole or lansoprazole for a minimum of 14 days for the trial to be considered a failure. Patient preference does not constitute treatment failure.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy)

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy)

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	
City:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN

REQUESTED DRUG:

- ❑ ACIPHEX
- ❑ NEXIUM
- ❑ PREVPAC
- ❑ ZEGERID
- ❑ DEXILANT

Requested Dosage: (must be completed)

Diagnosis:

- ❑ GERD
- ❑ H. pylori
- ❑ Hypersecretory conditions
- ❑ Peptic ulcer
- ❑ Duodenal ulcer
- ❑ Erosive esophagitis
- ❑ Barrett's esophagitis

Qualifications for coverage:

❑ Failed omeprazole, pantoprazole or lansoprazole

Was omeprazole/pantoprazole/lansoprazole trial for at least 14 days?
❑ YES ❑ NO

Dose:

Frequency:

❑ Adverse Reaction to omeprazole/pantoprazole/lansoprazole (attach FDA Medwatch form) or contraindicated (provide description below):

❑ Inability to take or tolerate oral tablets (must check a box below):
- ❑ Tube Fed
- ❑ Requires soft food or liquid administration

Other (provide description at right)

Physician Signature:	Date:

Part IV: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE:	FAX:

Part V: FOR OFFICIAL USE ONLY

NDC#:

Date: / /

Approved - Effective dates of PA: From: / / Initials: _____

Denied (Reasons): To: / /

NUVIGIL and PROVIGIL
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Nuvigil or Provigil 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.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ **Nuvigil _____** □ **Provigil_____**	**FDA approved indication for this request:** □ **Narcolepsy** □ **Excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome** □ **Shift work sleep disorder**
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

OLYSIO
PRIOR AUTHORIZATION

SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Olysio must meet the following criteria:

- Patient must be ≥ 18 years old.
- Must have a diagnosis of chronic hepatitis C, genotype 1.
- Liver biopsy confirming a Metavir score of F3 or F4, unless medically contraindicated; or documentation of severe extrahepatic manifestations of hepatitis C infection.
- Must be prescribed by a hepatologist, gastroenterologist, or infectious disease specialist.
- Must be used in combination with pegylated interferon and ribavirin. **(must not be used as monotherapy)**
- Alternative therapy should be considered for patients infected with HCV genotype 1a containing the Q80K polymorphism.
- Female patients must have a negative pregnancy test within 30 days prior to initiation of therapy and monthly during treatment.
- Documentation showing that patient is drug and alcohol free for the past 6 months.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	NAME OF SPECIALIST:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug: □ **Olysio** Dosage: _____	Presence of Q80K polymorphism? □ YES □ NO	Diagnosis for this request: Genotype:	Patient is drug and alcohol free for past 6 months: □ YES □ NO
	Documented liver fibrosis:	Pegylated interferon dose: Ribavirin dose:	Negative pregnancy test in the past 30 days □ YES □ NO
Has the patient been previously treated for chronic hepatitis C? □ YES □ NO If yes, please indicate past treatment regimen(s), dates of treatment, and response to therapy:			Baseline HCV RNA: HCV RNA 4 weeks after starting therapy:
PHYSICIAN SIGNATURE:			DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

ONFI
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Onfi must meet the following criteria:

- **Patient must have a diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS).**
- **Patient must be 2 years of age or older.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Onfi	Diagnosis for this request:
Dosing Instructions:	
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

OPHTHALMIC ANTIHISTAMINES
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Lastacaft, Bepreve, Patanol, and Pataday must first try one of the following:

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

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Lastacaft □ Bepreve □ Pataday	Diagnosis for this request:
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

ORACEA and SOLODYN
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Oracea or Solodyn must try a first line agent.

- **Doxycycline, minocycline, and tetracycline do not require a prior authorization.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage:		Diagnosis for this request:	
□ Failed Therapy Dose	Frequency	Start Date	End Date
PHYSICIAN SIGNATURE:			DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

ORAL ANTICOAGULANTS
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

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

- Patients must have an FDA approved indication.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ **Pradaxa** □ **Xarelto** □ **Eliquis**	Diagnosis for this request:
PHYSICIAN SIGNATURE: DATE:	

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

ORAVIG
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Oravig must first try clotrimazole troches, fluconazole tablets or nystatin suspension.

- **Clotrimazole troches, fluconazole tablets, and nystatin suspension do not require PA.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Oravig _____	Diagnosis for this request:
□ Medication failed and dose _____	**Start Date:** **End Date:**
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

QUALAQUIN
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Qualaquin must have a diagnosis of malaria.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Qualaquin	Diagnosis for this request:
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

RAYOS
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Rayos must meet the following criteria:

- Patient must first try generic prednisone.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ **Rayos**	Diagnosis for this request:
PHYSICIAN SIGNATURE: DATE:	

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

RELISTOR
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Relistor must meet the following criteria:

- Patient must be experiencing opioid-induced constipation.
- Patient must have advanced illness receiving palliative care.
- Patient must have tried and failed at least one other laxative.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ **Relistor**	Diagnosis for this request: Advanced illness:
PHYSICIAN SIGNATURE: DATE:	

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

SOMA 250 PA FORM
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Soma 250 must meet the following criteria:

- **Patient must first use carisoprodol 350mg.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy)

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy)

PHYSICIAN NAME:	PHYSICIAN MEDICAID ID NUMBER:	
City:	FAX: ( )	Phone: ( )

Part III: TO BE COMPLETED BY PHYSICIAN

REQUESTED DRUG:	**Requested Dosage:** (must be completed)
	Diagnosis for this request:

Qualifications for coverage:

□ Failed carisoprodol therapy	Start Date	End Date	Dose	Frequency

Physician Signature:	Date:

Part IV: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( )	FAX: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

SOVALDI
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Sovaldi must meet the following criteria:

- Patient must be ≥ 18 years old.
- Must have a diagnosis of chronic hepatitis C (genotypes 1, 2, 3, or 4).
- Liver biopsy confirming a Metavir score of F3 or F4, unless medically contraindicated; or documentation of severe extrahepatic manifestations of hepatitis C infection.
- Must be prescribed by a hepatologist, gastroenterologist, or infectious disease specialist.
- Must be used in combination with ribavirin or in combination with pegylated interferon and ribavirin. **(must not be used as monotherapy)**
- Female patients must have a negative pregnancy test within 30 days prior to initiation of therapy and monthly during treatment.
- Absence of renal impairment (eGFR must be >30mL/min/1.73m^2) and absence of end stage renal disease (ESRD).
- Documentation showing that patient is drug and alcohol free for the past 6 months.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH:

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	NAME OF SPECIALIST:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug: □ **Sovaldi** Dosage: _____	Diagnosis for this request: Genotype:	Documented liver fibrosis:	Patient is drug and alcohol free for past 6 months: □ YES □ NO	
		Pegylated interferon dose: Ribavirin dose:	Negative pregnancy test in the past 30 days: □ YES □ NO	eGFR:

Has the patient been previously treated for chronic hepatitis C? □ YES □ NO If yes, please indicate past treatment regimen(s), dates of treatment, and response to therapy:	Baseline HCV RNA: HCV RNA 4 weeks after starting therapy:
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX: ( )
DRUG:	NDC#

Part V: FOR OFFICIAL USE ONLY

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

SUBOXONE/SUBUTEX PA FORM
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD 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: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy)

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy)

PHYSICIAN NAME:	SAMHSA ID (X-DEA Number)	PHYSICIAN MEDICAID ID NUMBER:
City:	FAX: ( )	Phone: ( )

Part III: TO BE COMPLETED BY PHYSICIAN

REQUESTED DRUG:	**Requested Dosage:** (must be completed)
	Diagnosis for this request:

Qualifications for coverage:

Patient 16 years of age or older? ❑ YES ❑ NO

Patient taking other opioids, tramadol, or carisoprodol concurrently? ❑ YES ❑ NO

Physician Signature:	Date:

Part IV: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( )	FAX: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

TOPICAL ACNE AGENTS
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

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

- **Patients must first try and fail a generic topical acne agent (erythromycin, benzoyl peroxide, clindamycin, tretinoin, sodium sulfacetamide/sulfur)**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage:	Diagnosis for this request:
Failed therapy:	Dosage:
	Frequency:
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

TOPICAL KETOCONAZOLE PRODUCTS
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Extina, Xolegel, and Ketocon Plus must first try a covered ketoconazole medication.

- **Ketoconazole creams and shampoos do not require a prior authorization.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Extina □ Xolegel □ Ketocon Plus	Medication Failed: Start Date: End Date:
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

Serotonin (5-HT$_1$) Receptor Agonists
TRIPTAN PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Amerge, Axert, Frova, Maxalt, Relpax, Treximet or Zomig must try Imitrex (sumatriptan) as first line therapy.

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

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH:

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Amerge □ Relpax □ Axert □ Treximet □ Frova □ Zomig □ Maxalt	Diagnosis for this request:
□ Failed sumatriptan therapy (dose and frequency) _____	**Start Date:** **End Date:**
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

TYSABRI
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Tysabri must meet the following criteria:

- **Patient must have a confirmed diagnosis of relapsing multiple sclerosis (MS) or moderate to severe Crohn's Disease.**
- **Patient is 18 years of age or older.**
- **Patient must have a neurologist or gastroenterologist involved in therapy.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	NEUROLOGIST/GASTROENTEROLOGIST INVOLVED IN THERAPY:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Tysabri _____	Diagnosis for this request:
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

ULORIC
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Uloric must try allopurinol as first line therapy or have documented renal/hepatic dysfunction or intolerance of allopurinol.

- **Allopurinol does not require a prior authorization.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage:		Diagnosis for this request:	
□ Failed Allopurinol Therapy	Dose	Frequency	Start Date / End Date
□ Renal or Hepatic Impairment	□ Other (please explain) _____		
PHYSICIAN SIGNATURE:			DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

ULTRAM ER/RYZOLT PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients have a trial of tramadol before receiving a PA for Ultram ER or Ryzolt.

- **Patients must use generic tramadol for a minimum of 30 days for the trial to be considered a failure.**
- **Ultram ER and Ryzolt will have a quantity limit of 30 tablets per month.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
City:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Dosage: (must be completed)

Diagnosis for this request:

Qualifications for coverage:

❑ Patient is currently stable on Ultram ER/Ryzolt

❑ Failed trial of tramadol	Was tramadol trial for at least 30 days? ❑ YES ❑ NO	Tramadol Dose:
		Tramadol Frequency:

Adverse Reaction (attach FDA MedWatch form) or contraindication to tramadol: (provide description below):

Medical Justification for use of Ultram ER or Ryzolt without trial of tramadol:

Physician Signature: Date:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

VUSION PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a prescription for Vusion must use nystatin or OTC miconazole first line.

- **Nystatin or miconazole OTC may be prescribed WITHOUT a prior authorization**
- **Patients must use nystatin or OTC miconazole for a minimum of 14 days for the trial to be considered a failure.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:			PHYSICIAN PROVIDER NUMBER:
City:	State:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: (must be completed)	**Diagnosis for this request:**
Qualifications for coverage:	
❑ Failed trial of nystatin or OTC miconazole in the last 30 days	Was trial for at least 14 days? ❑ YES ❑ NO
Adverse Reaction (attach FDA Medwatch form) or contraindication: (provide description below):	
Medical Justification for use of Vusion without trial of miconazole or nystatin:	
Physician Signature:	Date:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

XELJANZ
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

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

- Prescription must be prescribed by or in consultation with a board certified rheumatologist.
- 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 for gastrointestinal perforations.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):		
RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH
Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):		
PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	RHEUMATOLOGIST NAME:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:	
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 Have or have had active hepatitis B or C virus □ YES □ NO	Failed Methotrexate therapy Start Date: End Date:
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION	
PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY	
Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	

XIFAXAN
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Xifaxan must meet the following criteria:

- Patient must have a diagnosis of travelers' diarrhea (TD) caused by noninvasive strains of E.coli and be 12 years of age or older.
- Patient must have a diagnosis of hepatic encephalopathy (HE) and be ≥ 18 years of age and failed a trial of lactulose.
- TD usual dose – 200mg three times a day for 3 days
- HE usual dose – 550mg twice a day (1100mg/day)

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ **Xifaxan 200mg** □ **Xifaxan 550mg**	Diagnosis for this request: Date of lactulose trial for Xifaxan 550mg:
PHYSICIAN SIGNATURE: DATE:	

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

XOLAIR PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a prescription for Xolair must have moderate to severe persistent asthma with a positive skin test or in vitro reactivity to a perennial aeroallergen and symptoms inadequately controlled with inhaled corticosteroids.

- **Xolair will be covered for patients with a diagnosis of moderate to severe persistent asthma who have elevated serum levels of IgE.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:			PHYSICIAN PROVIDER NUMBER:
City:	State:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: (must be completed)	**Specialist involved in therapy:**
	Diagnosis for this request:

Qualifications for coverage:

- ❑ IgE level (Give date of test and results)

_____

Adverse Reaction (attach FDA Medwatch form) or contraindication: (provide description below):

Medical Justification for use of Xolair without trial of inhaled corticosteroids:

Physician Signature: Date:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

XYREM PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Xyrem must meet the following criteria:

- **Patient must be 16 years of age or older.**
- **Patient must have a diagnosis of narcolepsy with cataplexy.**
- **Patient must have a diagnosis of narcolepsy with excessive daytime sleepiness with previous trial and failure of a standard stimulant agent (modafinil, armodafinil, methylphenidate, dextroamphetamine, or amphetamine/dextroamphetamine).**
- **Patient must be enrolled in the Xyrem Success Program.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN MEDICAID PROVIDER NUMBER:
PHYSICIAN ADDRESS:		
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug: (must be completed) **Diagnosis for this request:**			
Qualifications for coverage:			
❑ Failed stimulant therapy (list drug)	Start Date:	End Date:	Dose:
❑ Enrolled in Xyrem Success Program	Date:		
Physician Signature:			Date:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAIDPROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

PRODUCT DETAILS OF XTORO (FINAFLOXACIN OTIC SUSPENSION)

INDICATIONS AND USE: Xtoro is a quinolone antimicrobial indicated for the treatment of acute otitis externa (AOE) caused by susceptible strains of *Pseudomonas aeruginosa* and *Staphylococcus aureus.*

DOSAGE FORMS: Xtoro is available as 5 mL of finafloxacin otic suspension 0.3%.

ADMINISTRATION: Instill four drops in the affected ear(s) twice daily for seven days. For patients requiring use of an otowick, the initial dose can be doubled (to 8 drops) by 4 drops instilled into the affected ear twice daily for seven days.

WARNINGS AND PRECAUTIONS:

- Prolonged use of this product may lead to overgrowth of nonsusceptible organisms. Discontinue use if this occurs.
- Allergic reactions may occur in patients with a history of hypersensitivity to finafloxacin, to other quinolones, or to any of the components in this medication. Discontinue use if this occurs.

USE IN SPECIFIC POPULATIONS:

- Pregnancy category C. Xtoro should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
- Caution should be exercised when finafloxacin is administered to a nursing mother.
- The safety and efficacy of Xtoro in infants below one year of age have not been established.

ADVERSE REACTIONS: The most common adverse reactions occurring in 1% of patients with Xtoro were ear pruritus and nausea.

PATIENT COUNSELING INFORMATION:

- If a rash or allergic reaction occurs, discontinue the use of Xtoro and contact physician.
- Warm the bottle in hands before use to avoid dizziness which may result from the instillation of a cold solution.
- When using with otowick, instill 8 drops at the time of otowick insertion, then continue with 4 drops administered twice daily for 7 days.

References:

1. Xtoro [package insert]. Fort Worth, TX: Alcon Laboratories, Inc.; November 2014.

PRODUCT DETAILS OF HEMANGEOL (PROPRANOLOL HYDROCHLORIDE ORAL SOLUTION)

INDICATIONS AND USE: Hemangeol oral solution is a beta-adrenergic blocker indicated for the treatment of proliferating infantile hemangioma requiring systemic therapy.

DOSAGE FORMS: Oral solution: 4.28 mg/mL propranolol hydrochloride.

ADMINISTRATION:

- Initiate treatment at ages 5 weeks to 5 months.
- Starting dose is 0.15 mL/kg (0.6 mg/kg) twice daily. After 1 week, increase dose to 0.3 mL/kg (1.1 mg/kg) twice daily. After 2 weeks, increase to a maintenance dose of 0.4 mL/kg (1.7 mg/kg) twice daily.
- Administer doses at least 9 hours apart during or after feeding.
- Readjust dose for changes in the child's weight.
- Monitor heart rate and blood pressure for 2 hours after first dose or increasing dose.

WARNINGS AND PRECAUTIONS:

- Hypoglycemia: administer during or after feeding. Do not use in patients who are not able to feed or are vomiting.
- Bradycardia and hypotension.
- Bronchospasm: avoid use in patients with asthma or lower respiratory infection.
- Increased risk of stroke in PHACE syndrome.

USE IN SPECIFIC POPULATIONS:

- Pregnancy category C. Hemangeol is not intended to be prescribed to pregnant women.
- Hemangeol is not intended to be prescribed to breastfeeding women.
- The safety and effectiveness for infantile hemangioma have not been established in pediatric patients greater than 1 year of age.

ADVERSE REACTIONS: The most common adverse reactions occurring in ≥ 10% of patients were sleep disorders, aggravated respiratory tract infections, diarrhea, and vomiting.

PATIENT COUNSELING INFORMATION:

- There is a risk of hypoglycemia when given to infants who are not feeding regularly or who are vomiting. Skip dosing under such conditions.
- There is a potential risk for bradycardia, aggravation of pre-existing conduction disorders, and hypotension. Contact a healthcare provider in case of fatigue, pallor, slow or uneven heart beats, peripheral coldness, or fainting.
- There is a risk of bronchospasm or exacerbation of lower respiratory tract infections. Contact a healthcare provider or go to the nearest hospital emergency room if there are breathing problems or wheezing during treatment.
- Changes in sleep patterns may occur.

References:

1. Hemangeol [package insert]. Parsippany, NJ: Pierre Fabre Pharmaceuticals, Inc.; March 2014.

PRODUCT DETAILS OF AGENTS USED TO TREAT IDIOPATHIC PULMONARY FIBROSIS

INDICATIONS AND USE:

Drug	Indication
Ofev (nintedanib)	Ofev is a kinase inhibitor indicated for the treatment of idiopathic pulmonary fibrosis (IPF).
Esbriet (pirfenidone)	Esbriet is a pyridone indicated for the treatment of idiopathic pulmonary fibrosis (IPF).

COMPARISON:

Drug	Dose	Approximate Cost
Ofev (nintedanib)	150 mg twice daily approximately 12 hours apart	$144/capsule
Esbriet (pirfenidone)	801 mg (three capsules) three times daily taken with food	$31/capsule

HOW SUPPLIED:

Drug	How supplied
Ofev (nintedanib)	150 mg and 100 mg capsules
Esbriet (pirfenidone)	267 mg capsules

WARNINGS AND PRECAUTIONS:

Drug	Warnings and Precautions
Ofev (nintedanib)	• Elevated liver enzymes • Gastrointestinal disorders • Embryofetal toxicity • Arterial thromboembolic events
Esbriet (pirfenidone)	• Elevated liver enzymes • Photosensitivity and rash • Gastrointestinal disorders

ADVERSE REACTIONS:

Drug	Adverse Reactions
Ofev (nintedanib)	• The most common adverse reactions (incidence ≥5%) are diarrhea, nausea, abdominal pain, vomiting, liver enzyme elevation, decreased appetite, headache, weight decreased, and hypertension.
Esbriet (pirfenidone)	• The most common adverse reactions (incidence ≥10%) are nausea, rash, abdominal pain, upper respiratory tract infection, diarrhea, fatigue, headache, dyspepsia, dizziness, vomiting, anorexia, gastro-esophageal reflux disease, sinusitis, insomnia, weight decreased, and arthralgia.

DRUG INTERACTIONS:

Drug	Drug Interactions
Ofev (nintedanib)	Coadministration of P-gp and CYP3A4 inhibitors may increase nintedanib exposure. Monitor patients closely for tolerability of Ofev.
Esbriet (pirfenidone)	Moderate (e.g., ciprofloxacin) and strong inhibitors of CYP1A2 (e.g., fluvoxamine) increase systemic exposure of Esbriet and may alter the adverse reaction profile of Esbriet. Discontinue fluvoxamine prior to administration of Esbriet or reduce to one capsule three times a day. Consider dosage reduction with use of ciprofloxacin.

References:

1. Ofev [package insert]. Ridgefield, CT: Boehringer Ingelheim Pharmaceuticals, Inc.; October 2014.
2. Esbriet [package insert]. Brisbane, CA: InterMune, Inc.; October 2014.