

EVZIO 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 Evzio must meet the following criteria:

• Patient must be taking opioids (over 100mg of morphine equivalents daily) or taking opioids with other interacting medications (benzos, muscle relaxants, etc.)

Part I: RECIPIENT INFORMATIO	N (To be completed by physician's represe	entative or	pharmacy):	
RECIPIENT NAME:	MEDICAID ID NUMBER:		RECIPIENT DATE OF BIRTH	
Part II: PHYSICIAN INFORMATIO	N (To be completed by physician's repres	entative or	pharmacy):	
PHYSICIAN NAME:	PHYSICIAN DEA NUMBER	:		
CITY:	PHONE: ()		FAX: ()	
	,		,	
D. A.W. TO DE COMPLETED DV	PUNCIONAL		1	
Part III: TO BE COMPLETED BY Requested Drug:	Diagnosis for this Request:	Is pat	Is patient opioid dependent and/or considered high risk for opioid overdose:	
	g			
		□ Yes	s 🗆 No	
List other interacting medications:		I	_	
PHYSICIAN SIGNATURE:			DATE:	
Part IV: PHARMACY INFORMAT	ION			
PHARMACY NAME:		SD MEDICAID		
			PROVIDER NUMBER:	
PHONE: ():			FAX:: ()	
THORE. ().			1700 ()	
DRUG:			NDC#:	
Part V: FOR OFFICIAL USE ONL	v			
TAIL V. TOR OTTIOIAL OOL ONL	<u></u>			
Date: /	1		Initials:	
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Approved - Effective dates of PA: From: / /			To: / /	
Denied: (Reasons)				