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#: