South Dakota Department of Social Services

Medicaid P&T Committee Meeting

March 21, 2014

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

Friday, March 21, 2014
1:00 – 3:00 PM

Sioux Falls Convention Center
Ballroom B
1201 N. West Avenue
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

- **Quantity Limits**
- **Brisdelle**
- **Review PA forms and criteria**

New Business

- **Review of Sovaldi**
- **Review of Olysio**
- **Review of Luzu**
- **Review of Hetlioz**

Oral Presentations and Comments by Manufacturers' Representatives

Next Meeting Date/Adjournment

Minutes of the December 6, 2013
Pharmacy & Therapeutics (P&T) Committee Meeting
South Dakota Department of Social Services, Division of Medical Services

Members Present

Mikel Holland, MD; Lenny Petrik, PharmD; Richard Holm, MD; Michelle Baack, MD; Bill Ladwig, RPh; James Engelbrecht, MD

DSS staff present

Mike Jockheck, RPh; Ann Schwartz, Dep. Director of Medical Services

Administrative Business

The P&T meeting was called to order by B. Ladwig at 1:00pm. The minutes of the September 20, 2013 meeting were presented. M. Baack made a motion to approve. R. Holm seconded the motion. The motion was approved unanimously.

Prior Authorization Update and Statistics

The committee reviewed the prior authorization (PA) activity for October 2013. There were a total of 3,554 PA's processed in the month of October, with 99.66% of those requests responded to in less than eight hours. There were 2,679 (75%) requests received electronically and 875 (25%) 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 7/1/2013 – 9/30/2013. The top five classes were antipsychotics, respiratory and CNS stimulants, amphetamines, central nervous system agents, misc., and corticosteroids (respiratory tract). The top 15 therapeutic classes make up 39.99% 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 10.50% of total claims.

Quantity Limit Review

The committee reviewed a list of quantity limit suggestions sorted by Rx count. It was requested that the list be sorted by drug name to remove duplicate entries. An updated list will be reviewed at the next meeting.

Tramadol Utilization Review

The committee reviewed tramadol utilization. It was requested that the current PA form be brought to the next meeting for review.

Hydrocodone Utilization Review

The committee reviewed hydrocodone utilization and the FDA drug safety communication regarding acetaminophen in prescription drug products. M. Baack made a motion that drug products containing strengths of hydrocodone/acetaminophen other than 5/325 and 10/325 should require a prior authorization. R. Holm seconded the motion. There was no public comment. The motion passed with no audible dissent.

Epinephrine Auto-Injection Devices Review
The committee reviewed utilization data for epinephrine auto-injectors. There was no public comment. This topic was tabled.

Brisdelle Review
The committee reviewed clinical information regarding Brisdelle. J. Engelbrecht made a motion to place Brisdelle on prior authorization. L. Petrick seconded the motion. There was no public comment. The motion passed with no audible dissent. A form will be brought back to the next meeting.

The next meeting is scheduled for March 21, 2014. J. Engelbrecht made a motion to adjourn the P&T Committee meeting. R. Holm seconded the motion. The motion passed unanimously and the meeting was adjourned.

HEALTH INFORMATION DESIGNS

South Dakota Medicaid
Monthly Prior Authorization Report
January 1, 2014 – January 31, 2014

Time Ratio

Total PAs	Response Under 8 Hours	Response Over 8 Hours	% Under 8 Hours	% Over 8 Hours
2,907	2,903	4	99.86%	0.14%

By Form Type

Form Type	Description	Approve	Deny
ADP	Antidepressant	142	243
ALT	Altabax	0	2
AMB	Ambien CR	7	17
ANF	Anti-Infectives(anti-biotic)	0	5
ANT	Antihistamines	8	67
APS	Antipsychotic	260	226
ARB	ARBS	9	32
COA	Oral Anticoagulants	6	12
DAW	Dispense As Written	13	52
EME	Antiemetics	0	1
GRH	Growth Hormone	2	2
GSM	Genitourinary SMR	6	31
HLM	Head Lice Medication	2	60
HOR	Horizant	1	1
LID	Lidoderm	3	90
MAX	Max Units Override	65	991
NAR	Name Brand Narcotics	2	2
NUC	Opioids	10	18
ONF	Onfi	13	12
OPH	Ophthalmic Antihistamines	0	10
PPI	Proton Pump Inhibitors	29	114
SAN	Sancuso	1	0
SMR	Skeletal Muscle Relaxants	0	4
STE	Nasal Steroids	10	49
STI	Stimulants	6	23
SUB	Suboxone/Subutex	4	10
TIM	Targeted Immune Modulators	8	11
TOP	Topical Acne Agents	19	110
TRP	Triptans	20	33
ULT	Ultram ER	5	1
XIF	Xifaxan	2	24
XOI	Xanthine Oxidase Inhibitor	1	0
Totals		654	2253

HEALTH INFORMATION DESIGNS

South Dakota Medicaid
Monthly Prior Authorization Report
January 1, 2014 – January 31, 2014

By Request Type

01/01/14 - 01/31/14	# of Requests	Electronic Requests		Faxed Requests	
		#	%	#	%
Prior Authorizations:					
Antidepressant	385	272	71%	113	29%
Altabax	2	1	50%	1	50%
Ambien CR	24	19	79%	5	21%
Anti-Infectives(anti-biotic)	5	4	80%	1	20%
Antihistamines	75	63	84%	12	16%
Antipsychotic	486	302	62%	184	38%
ARBS	41	33	80%	8	20%
Oral Anticoagulants	18	11	61%	7	39%
Dispense As Written	65	43	66%	22	34%
Antiemetics	1	1	100%	0	0%
Growth Hormone	4	2	50%	2	50%
Genitourinary SMR	37	28	76%	9	24%
Head Lice Medication	62	54	87%	8	13%
Horizant	2	2	100%	0	0%
Lidoderm	93	75	81%	18	19%
Max Units Override	1,056	986	93%	70	7%
Name Brand Narcotics	4	0	0%	4	100%
Opioids	28	24	86%	4	14%
Onfi	25	6	24%	19	76%
Ophthalmic Antihistamines	10	10	100%	0	0%
Proton Pump Inhibitors	143	111	78%	32	22%
Sancuso	1	0	0%	1	100%
Skeletal Muscle Relaxants	4	4	100%	0	0%
Nasal Steroids	59	46	78%	13	22%
Stimulants	29	24	83%	5	17%
Suboxone/Subutex	14	9	64%	5	36%
Targeted Immune Modulators	19	12	63%	7	37%
Topical Acne Agents	129	101	78%	28	22%
Triptans	53	42	79%	11	21%
Ultram ER	6	5	83%	1	17%
Xifaxan	26	21	81%	5	19%
Xanthine Oxidase Inhibitor	1	1	100%	0	0%
Prior Authorization Totals	2907	2312	80%	595	20%

HEALTH INFORMATION DESIGNS

South Dakota Medicaid
Monthly Prior Authorization Report
January 1, 2014 – January 31, 2014

Electronic PAs (unique)

01/01/14 - 01/31/14	# Requests	# Approved	% Approved	# Denied	% Denied	Cost Savings
Prior Authorizations:						
Antidepressant	272	72	26%	200	74%	$24,660.00
Altabax	1	0	0%	1	100%	$70.69
Ambien CR	19	7	37%	12	63%	$1,171.68
Anti-Infectives(anti-biotic)	4	0	0%	4	100%	$337.60
Antihistamines	63	5	8%	58	92%	$3,204.50
Antipsychotic	302	115	38%	187	62%	$80,198.69
ARBS	33	4	12%	29	88%	$1,805.25
Oral Anticoagulants	11	2	18%	9	82%	$2,757.06
Dispense As Written	43	0	0%	43	100%	$3,225.00
Antiemetics	1	0	0%	1	100%	$745.36
Growth Hormone	2	0	0%	2	100%	$5,016.00
Genitourinary SMR	28	4	14%	24	86%	$2,456.88
Head Lice Medication	54	0	0%	54	100%	$6,733.26
Horizant	2	1	50%	1	50%	$121.04
Lidoderm	75	0	0%	75	100%	$23,110.50
Max Units Override	986	25	3%	961	97%	$47,500.00
Opioids	24	8	33%	16	67%	$2,150.40
Onfi	6	0	0%	6	100%	$3,085.80
Ophthalmic Antihistamines	10	0	0%	10	100%	$954.20
Proton Pump Inhibitors	111	15	14%	96	86%	$11,760.00
Skeletal Muscle Relaxants	4	0	0%	4	100%	$2,085.68
Nasal Steroids	46	3	7%	43	93%	$4,730.00
Stimulants	24	2	8%	22	92%	$8,151.44
Suboxone/Subutex	9	0	0%	9	100%	$2,018.16
Targeted Immune Modulators	12	3	25%	9	75%	$14,917.32
Topical Acne Agents	101	10	10%	91	90%	$14,408.94
Triptans	42	14	33%	28	67%	$3,301.48
Ultram ER	5	4	80%	1	20%	$142.58
Xifaxan	21	0	0%	21	100%	$21,000.00
Xanthine Oxidase Inhibitor	1	1	100%	0	0%	$0.00
Prior Authorization Totals	2312	295	13%	2017	87%	$291,819.51

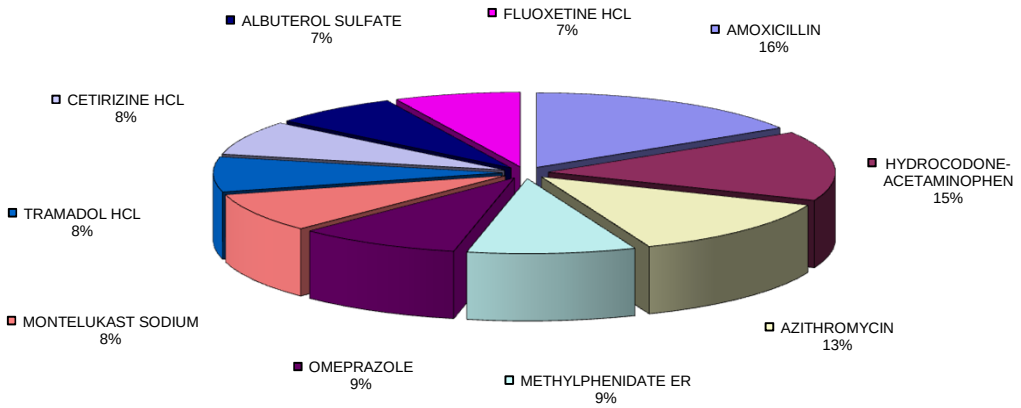
SOUTH DAKOTA MEDICAID
Cost Management Analysis

TOP 25 DRUGS BASED ON NUMBER OF CLAIMS FROM 10/01/2013 - 12/31/2013

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
AMOXICILLIN	PENICILLINS	6,363	$ 53,508.93	$ 8.41	3.27%
HYDROCODONE-ACETAMINOPHEN	OPIATE AGONISTS	5,962	$ 91,492.45	$ 15.35	3.07%
AZITHROMYCIN	MACROLIDES	5,046	$ 79,100.84	$ 15.68	2.60%
METHYLPHENIDATE ER	RESPIRATORY AND CNS STIMULANTS	3,718	$ 613,749.38	$ 165.08	1.91%
OMEPRAZOLE	PROTON-PUMP INHIBITORS	3,610	$ 42,445.39	$ 11.76	1.86%
MONTELUKAST SODIUM	LEUKOTRIENE MODIFIERS	3,317	$ 69,588.06	$ 20.98	1.71%
TRAMADOL HCL	OPIATE AGONISTS	2,982	$ 22,774.58	$ 7.64	1.53%
CETIRIZINE HCL	SECOND GENERATION ANTIHISTAMINES	2,936	$ 23,717.86	$ 8.08	1.51%
ALBUTEROL SULFATE	BETA-ADRENERGIC AGONISTS	2,805	$ 48,566.69	$ 17.31	1.44%
FLUOXETINE HCL	ANTIDEPRESSANTS	2,791	$ 22,521.04	$ 8.07	1.44%
VYVANSE	AMPHETAMINES	2,768	$ 489,039.20	$ 176.68	1.42%
LEVOTHYROXINE SODIUM	THYROID AGENTS	2,644	$ 23,497.85	$ 8.89	1.36%
SERTRALINE HCL	ANTIDEPRESSANTS	2,486	$ 19,409.39	$ 7.81	1.28%
DEXTROAMPHETAMINE-AMPHETAMINE	AMPHETAMINES	2,129	$ 298,428.34	$ 140.17	1.10%
LORATADINE	SECOND GENERATION ANTIHISTAMINES	2,072	$ 12,658.74	$ 6.11	1.07%
TRAZODONE HCL	ANTIDEPRESSANTS	2,049	$ 12,332.47	$ 6.02	1.05%
LISINOPRIL	ANGIOTENSIN-CONVERTING ENZYME INHIBITORS	1,963	$ 10,994.30	$ 5.60	1.01%
INTUNIV	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	1,956	$ 420,080.00	$ 214.76	1.01%
VENTOLIN HFA	BETA-ADRENERGIC AGONISTS	1,955	$ 87,852.86	$ 44.94	1.01%
AMOX TR-POTASSIUM CLAVULANATE	PENICILLINS	1,790	$ 50,120.49	$ 28.00	0.92%
RISPERIDONE	ANTIPSYCHOTIC AGENTS	1,783	$ 28,514.60	$ 15.99	0.92%
SULFAMETHOXAZOLE-TRIMETHOPRIM	SULFONAMIDES (SYSTEMIC)	1,769	$ 13,613.12	$ 7.70	0.91%
CLONIDINE HCL	CENTRAL ALPHA-AGONISTS	1,739	$ 11,961.91	$ 6.88	0.89%
CEFDINIR	CEPHALOSPORINS	1,671	$ 81,362.58	$ 48.69	0.86%
CLONAZEPAM	BENZODIAZEPINES (ANTICONVULSANTS)	1,618	$ 13,303.57	$ 8.22	0.83%
TOTAL TOP 25		69,922	$ 2,640,634.64	$ 37.77	35.98%

Total Rx Claims From 10/01/2013 - 12/31/2013	194,309

Top 10 Drugs
Based on Number of Claims



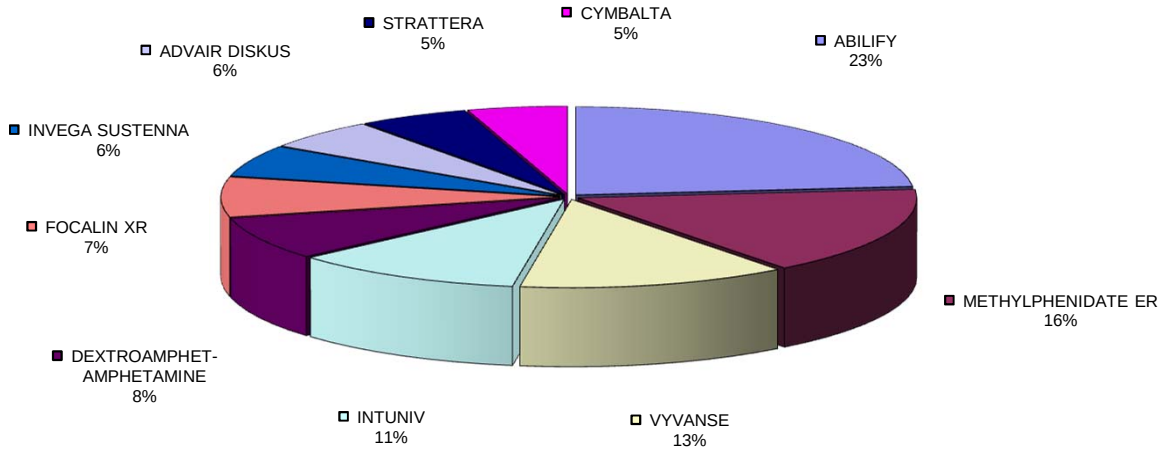
SOUTH DAKOTA MEDICAID
Cost Management Analysis

TOP 25 DRUGS BASED ON TOTAL CLAIMS COST FROM 10/01/2013 - 12/31/2013

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
ABILIFY	ANTIPSYCHOTIC AGENTS	1,461	$ 892,972.06	$ 611.21	0.75%
METHYLPHENIDATE ER	RESPIRATORY AND CNS STIMULANTS	3,718	$ 613,749.38	$ 165.08	1.91%
VYVANSE	AMPHETAMINES	2,768	$ 489,039.20	$ 176.68	1.42%
INTUNIV	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	1,956	$ 420,080.00	$ 214.76	1.01%
DEXTROAMPHET-AMPHETAMINE	AMPHETAMINES	2,129	$ 298,428.34	$ 140.17	1.10%
FOCALIN XR	RESPIRATORY AND CNS STIMULANTS	1,244	$ 277,500.38	$ 223.07	0.64%
INVEGA SUSTENNA	ANTIPSYCHOTIC AGENTS	154	$ 220,470.79	$ 1,431.63	0.08%
ADVAIR DISKUS	CORTICOSTEROIDS (RESPIRATORY TRACT)	766	$ 210,744.71	$ 275.12	0.39%
STRATTERA	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	956	$ 200,900.49	$ 210.15	0.49%
CYMBALTA	ANTIDEPRESSANTS	671	$ 181,881.93	$ 271.06	0.35%
PULMOZYME	MUCOLYTIC AGENTS	56	$ 168,188.39	$ 3,003.36	0.03%
PREVACID	PROTON-PUMP INHIBITORS	666	$ 164,992.82	$ 247.74	0.34%
LYRICA	ANTICONVULSANTS, MISCELLANEOUS	602	$ 156,433.11	$ 259.86	0.31%
OXYCONTIN	OPIATE AGONISTS	446	$ 146,260.26	$ 327.94	0.23%
LANTUS SOLOSTAR	INSULINS	425	$ 139,757.19	$ 328.84	0.22%
COPAXONE	IMMUNOMODULATORY AGENTS	29	$ 138,886.06	$ 4,789.17	0.01%
LATUDA	ANTIPSYCHOTIC AGENTS	232	$ 135,460.19	$ 583.88	0.12%
HUMIRA	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	53	$ 131,824.57	$ 2,487.26	0.03%
FLOVENT HFA	CORTICOSTEROIDS (RESPIRATORY TRACT)	809	$ 131,421.62	$ 162.45	0.42%
BUDESONIDE	CORTICOSTEROIDS (RESPIRATORY TRACT)	420	$ 119,821.03	$ 285.29	0.22%
NEXIUM	PROTON-PUMP INHIBITORS	445	$ 116,100.13	$ 260.90	0.23%
NOVOLOG	INSULINS	383	$ 107,263.73	$ 280.06	0.20%
ENBREL	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	44	$ 101,298.86	$ 2,302.25	0.02%
XENAZINE	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	13	$ 93,508.99	$ 7,193.00	0.01%
SEROQUEL XR	ANTIPSYCHOTIC AGENTS	177	$ 93,083.20	$ 525.89	0.09%
TOTAL TOP 25		20,623	$ 5,750,067.43	$ 278.82	10.61%

Total Rx Claims From 10/01/2013 - 12/31/2013	194,309

Top 10 Drugs
Based on Total Claims Cost



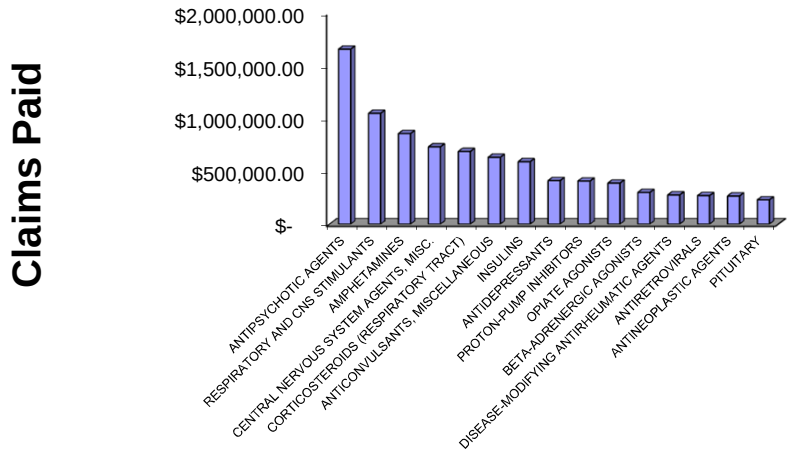
SOUTH DAKOTA MEDICAID
Cost Management Analysis

TOP 15 THERAPEUTIC CLASSES BY TOTAL COST OF CLAIMS FROM 10/01/2013 - 12/31/2013

AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
ANTIPSYCHOTIC AGENTS	6,860	$ 1,656,687.94	$ 241.50	3.53%
RESPIRATORY AND CNS STIMULANTS	6,544	$ 1,051,033.03	$ 160.61	3.37%
AMPHETAMINES	5,792	$ 858,934.97	$ 148.30	2.98%
CENTRAL NERVOUS SYSTEM AGENTS, MISC.	2,996	$ 732,991.50	$ 244.66	1.54%
CORTICOSTEROIDS (RESPIRATORY TRACT)	2,941	$ 689,196.59	$ 234.34	1.51%
ANTICONVULSANTS, MISCELLANEOUS	8,198	$ 633,647.76	$ 77.29	4.22%
INSULINS	2,041	$ 592,617.94	$ 290.36	1.05%
ANTIDEPRESSANTS	15,646	$ 412,630.98	$ 26.37	8.05%
PROTON-PUMP INHIBITORS	5,947	$ 408,453.74	$ 68.68	3.06%
OPIATE AGONISTS	13,296	$ 389,506.92	$ 29.30	6.84%
BETA-ADRENERGIC AGONISTS	7,116	$ 300,661.01	$ 42.25	3.66%
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	146	$ 277,120.65	$ 1,898.09	0.08%
ANTIRETROVIRALS	244	$ 270,349.08	$ 1,107.99	0.13%
ANTINEOPLASTIC AGENTS	442	$ 266,764.08	$ 603.54	0.23%
PITUITARY	500	$ 229,806.29	$ 459.61	0.26%
TOTAL TOP 15	78,709	$ 8,770,402.48	$ 111.43	40.51%

Total Rx Claims From 10/01/2013 - 12/31/2013	194,309

Top 15 Therapeutic Classes
Based on Total Cost of Claims



SD Medicaid Quantity Limit Suggestions					
Drug Name	**Strength**	**Rx Count**	**Suggested Max Supply**	**Max Days**	**Committee**
ACETAMINOPHEN-CODEINE	300MG-30MG	1081	340	34	
ALBUTEROL SULFATE	2.5 MG/3ML	3431	360	30	
AMOX TR-POT CLAVULANATE	875-125 MG	375	68	34	
AMOXICILLIN	500 MG	1901	204	34	
AMPHETAMINE SALT COMBO	10 MG	397	136	34	
AZITHROMYCIN	250 MG	2430	36	30	
AZITHROMYCIN	200 MG/5ML	3117	180	30	
AZITHROMYCIN	100 MG/5ML	966	180	30	
BUDESONIDE	0.5 MG/2ML	507	120	30	
BUDESONIDE	0.25MG/2ML	339	120	30	
CEFDINIR	250 MG/5ML	1071	600	30	
CEFDINIR	125 MG/5ML	353	600	30	
CEFPROZIL	250 MG/5ML	431	600	30	
CEPHALEXIN	500 MG	961	272	34	
CETIRIZINE HCL	1 MG/ML	834	340	34	
CHERATUSSIN AC	100-10MG/5	952	240		60 DACON
CHLORHEXIDINE GLUCONATE	0.12%	665	473	15	
CIPRODEX	0.3 %-0.1%	651	15	10	
CLONAZEPAM	0.5 MG	706	136	34	136
CLONAZEPAM	1 MG	438	136	34	136
CLONIDINE HCL	0.1 MG	980	136	34	136
CLOZAPINE	100 MG	332	306	34	
CYCLOBENZAPRINE HCL	10 MG	1236	102	34	
DESMOPRESSIN ACETATE	0.2 MG	406	204	34	
ERYTHROMYCIN	5MG/G	336	4	1	
FLUCONAZOLE	150 MG	783	34	34	
FUROSEMIDE	40 MG	357	68	34	
GABAPENTIN	300 MG	422	204	34	
HYDROCHLOROTHIAZIDE	25 MG	485	136	34	
HYDROCODONE-APAP	5MG-325MG	4989	408	34	
HYDROCODONE-APAP	7.5-500/15	662		34	
HYDROCODONE-APAP	5 MG-500MG	1965	136	34	
HYDROCODONE-APAP	10MG-325MG	980	408	34	
IBUPROFEN	800 MG	1704	102	34	102
IBUPROFEN	600 MG	404	102	34	102
INTUNIV	2 MG	1346	34	34	34
INTUNIV	3 MG	936	34	34	34
INTUNIV	4 MG	706	34	34	34
INTUNIV	1 MG	669	34	34	34
LANTUS SOLOSTAR	100/ML (3)	816	300	150	
LORAZEPAM	1 MG	449	136	34	136
METRONIDAZOLE	500 MG	333	102	34	
MINOCYCLINE HCL	100 MG	519	68	34	
MUPIROCIN	2%	1489	22	30	
NAPROXEN	500 MG	461	102	34	

SD Medicaid Quantity Limit Suggestions					
Drug Name	**Strength**	**Rx Count**	**Suggested Max Supply**	**Max Days**	**Committee**
NITROFURANTOIN MONO-MACRO	100 MG	337	136	34	
ONDANSETRON ODT	4 MG	1100	136	34	
OXYCODONE HCL	5 MG	385	408	34	
OXYCODONE-ACETAMINOPHEN	5MG-325MG	1786	408	34	
PERMETHRIN	0.05	942	60	5	
POLYMYXIN B SUL-TRIMETH	10K/ML-0.1	335	10	1	
PRENATAL PLUS	27 MG-1 MG	1768	34	34	
PROMETHAZINE-CODEINE	6.25-10/5	786	240		60 DACON
SERTRALINE HCL	100 MG	1305	68	34	68
SPIRIVA	18 MCG	474	30	30	
SULFAMETH-TRIMETHOPRIM	800-160 MG	1466	600	30	
SULFAMETH-TRIMETHOPRIM	200-40MG/5	1466	68	34	
TAMIFLU	6 MG/ML	699	120	10	
TRAZODONE HCL	100 MG	578	136	34	
TRAZODONE HCL	50 MG	2172	272	34	

BRISDELLE
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 Brisdelle must meet the following criteria:

- Patient must first try paroxetine.

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: □ **Brisdelle**	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)

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

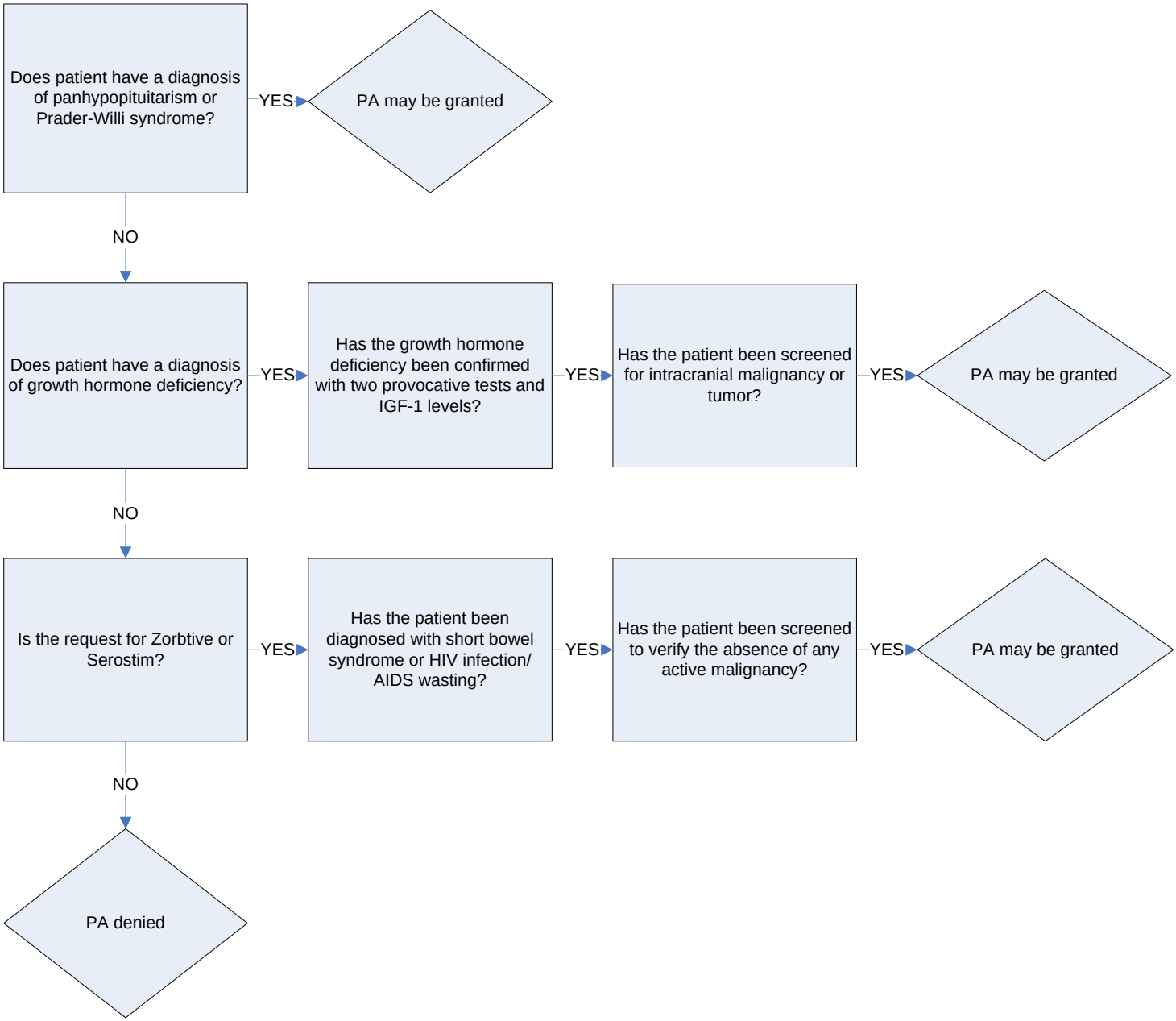
4. Does the patient have any of the following contraindications? Check all that apply.
☐ Proliferative Diabetic retinopathy ☐ Benign intracranial hypertension ☐ NONE

Physician signature:	Date:

Part IV: PHARMACY INFORMATION

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

South Dakota Department of Social Services
Adult Growth Hormone Criteria



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:

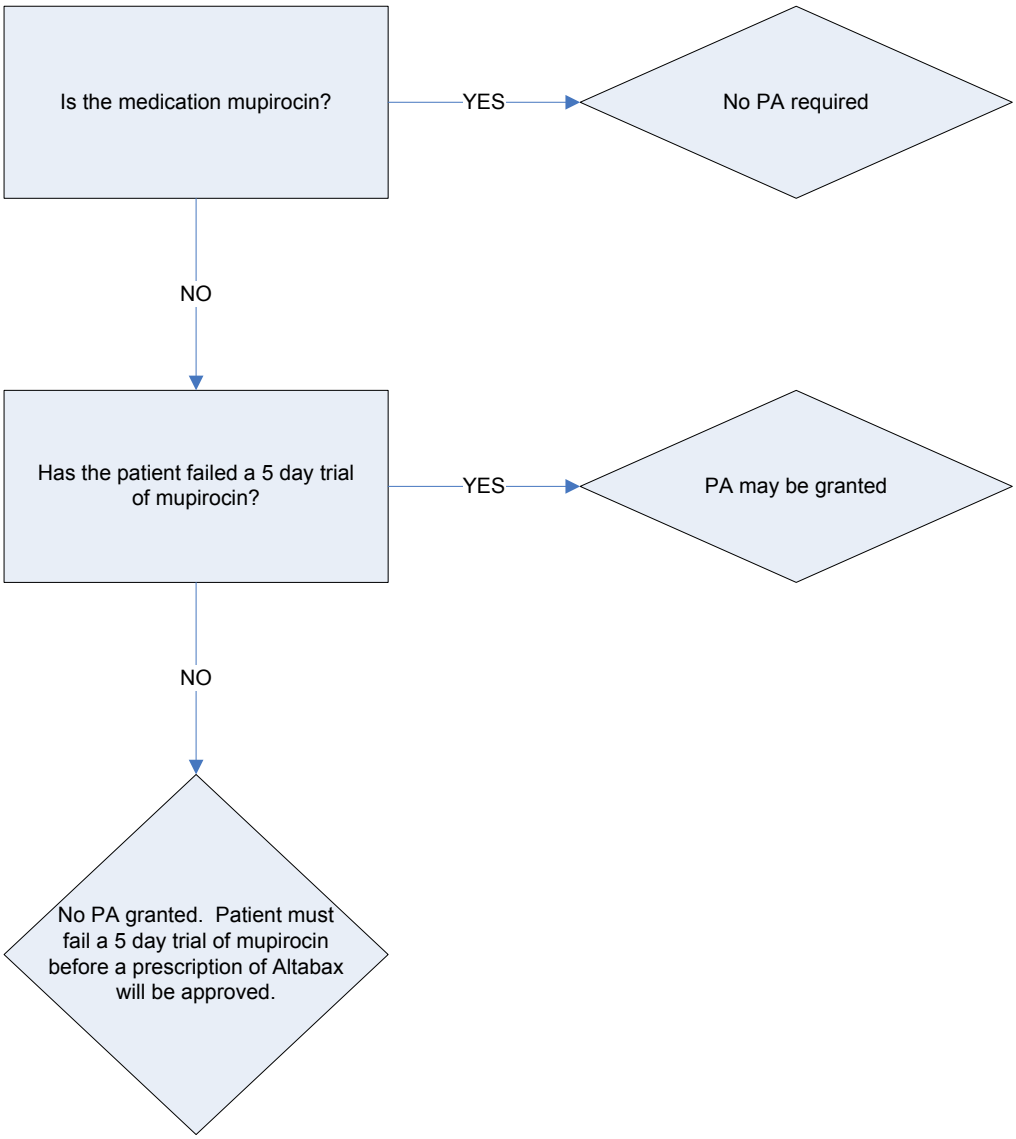
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Altabax Prior Authorization Criteria



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

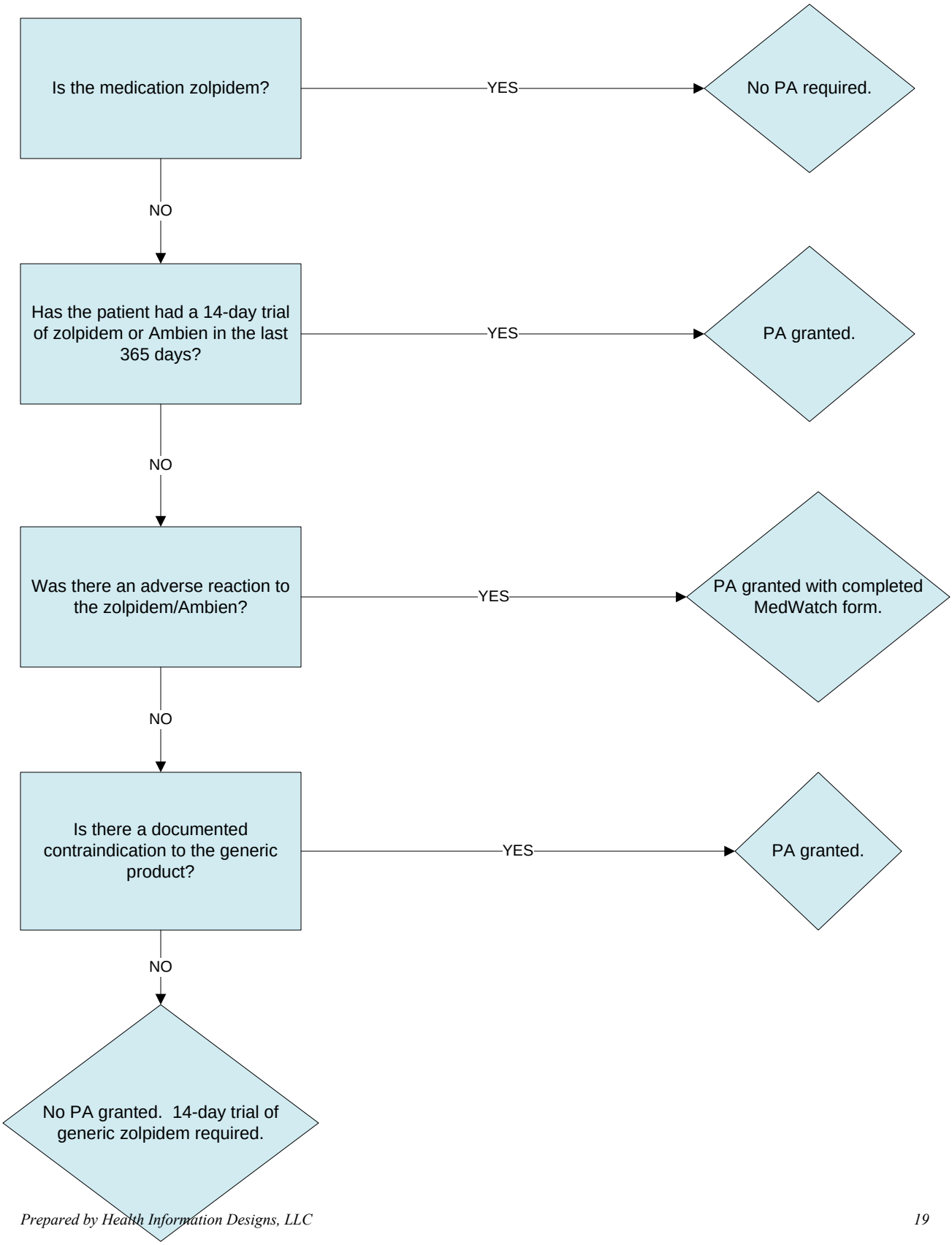
PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services

Ambien CR Criteria Algorithm



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:

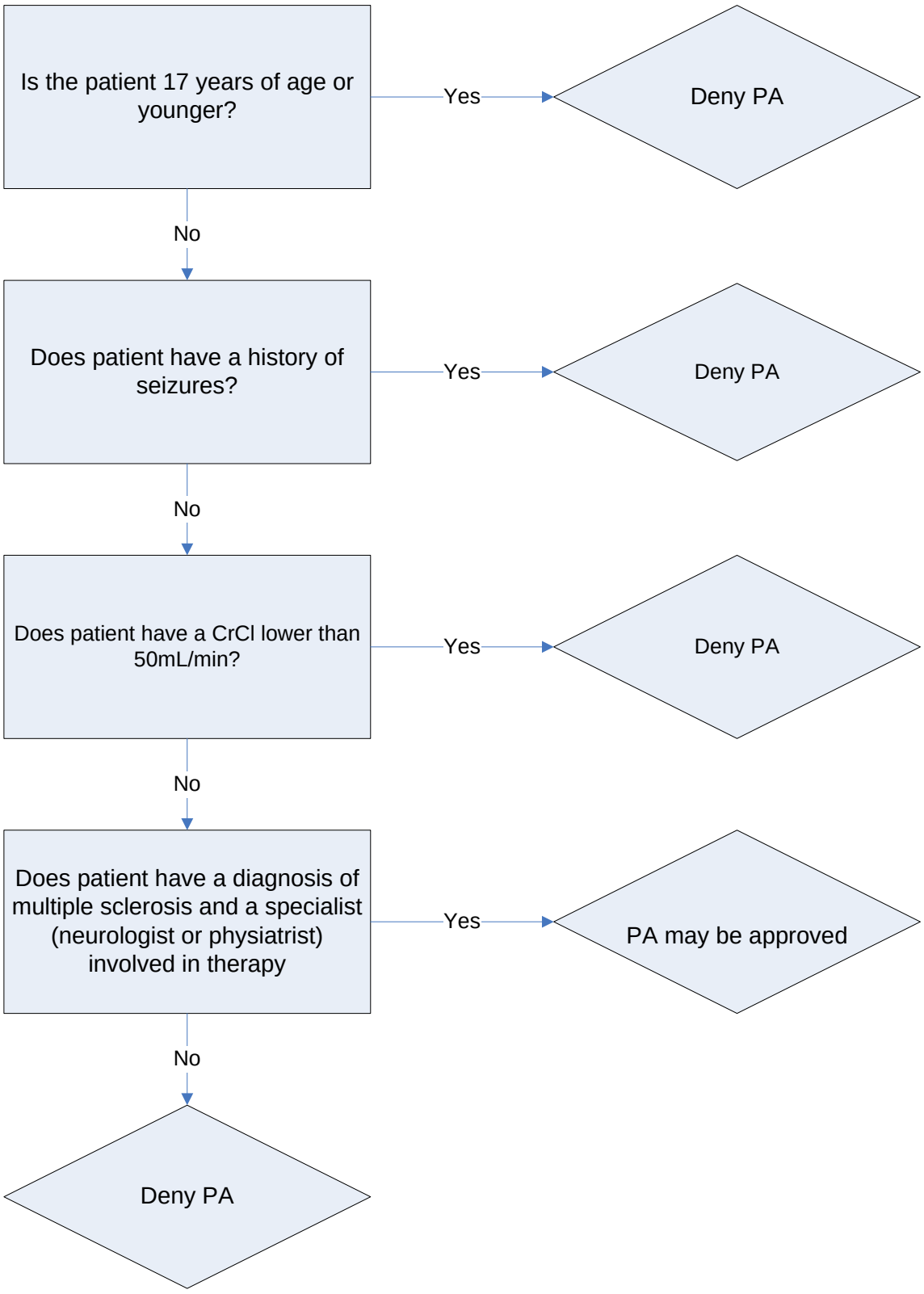
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Ampyra Prior Authorization Algorithm



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:

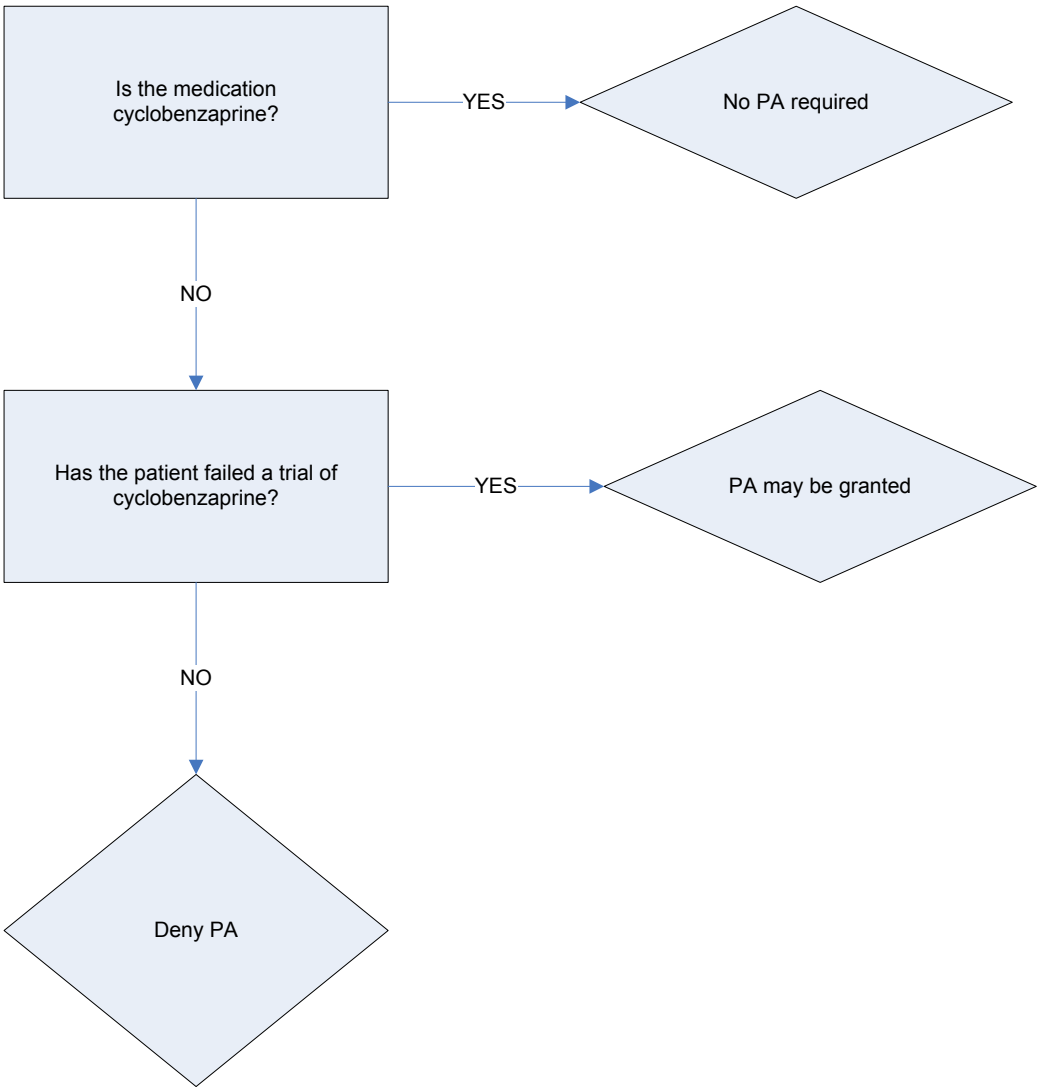
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Amrix and Fexmid Prior Authorization Criteria



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:

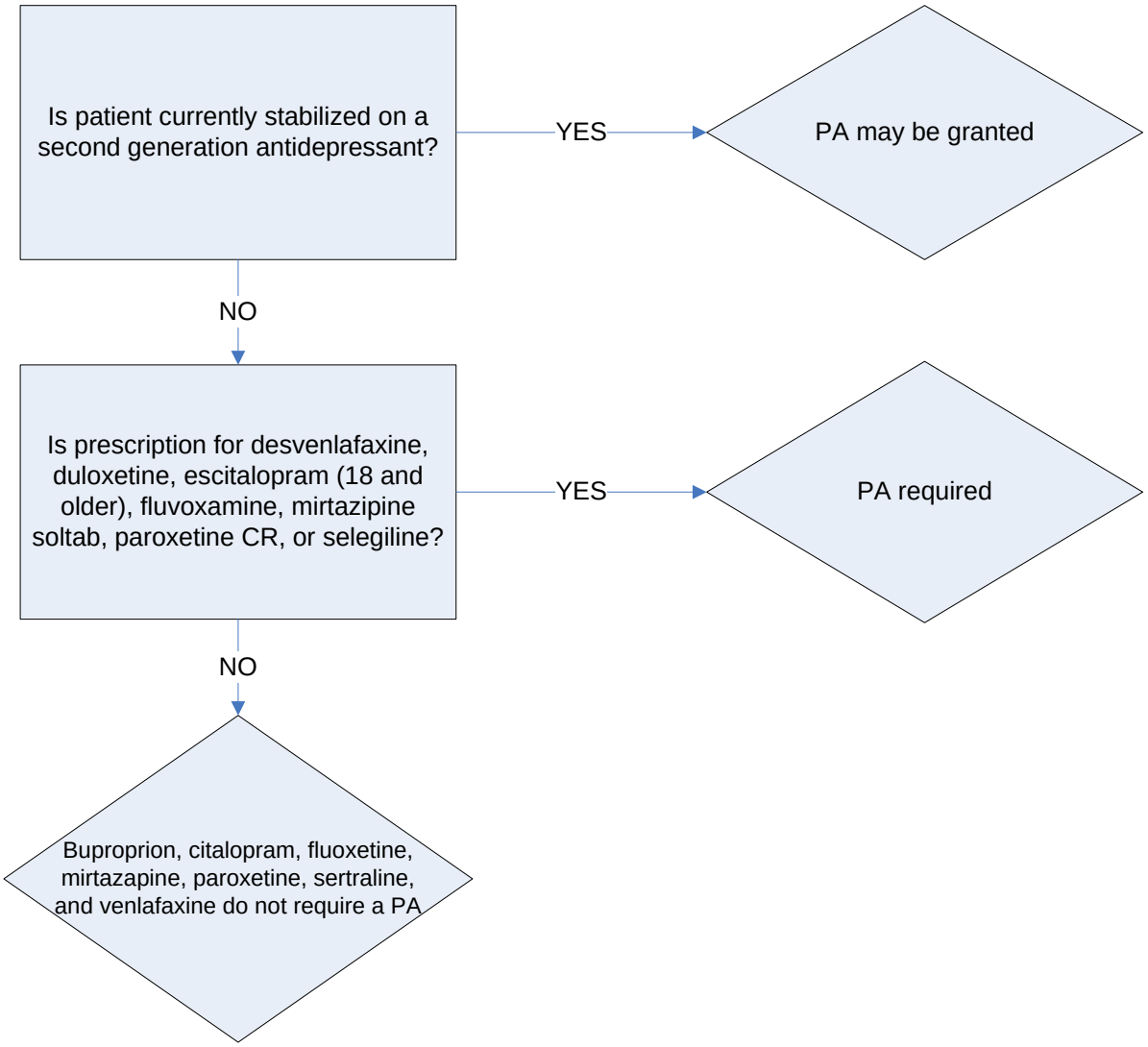
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Antidepressant Authorization Criteria



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:

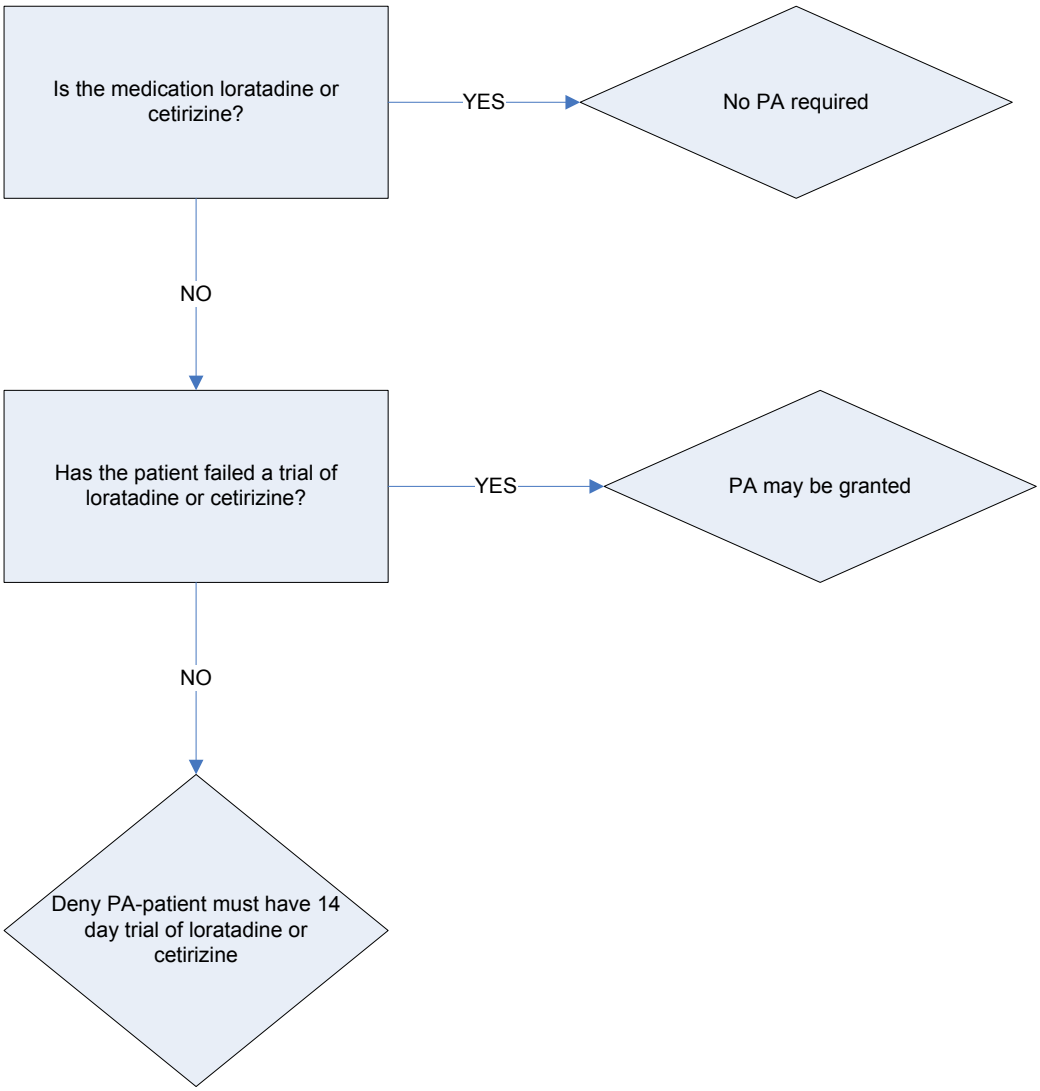
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Antihistamine Prior Authorization Criteria



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:**

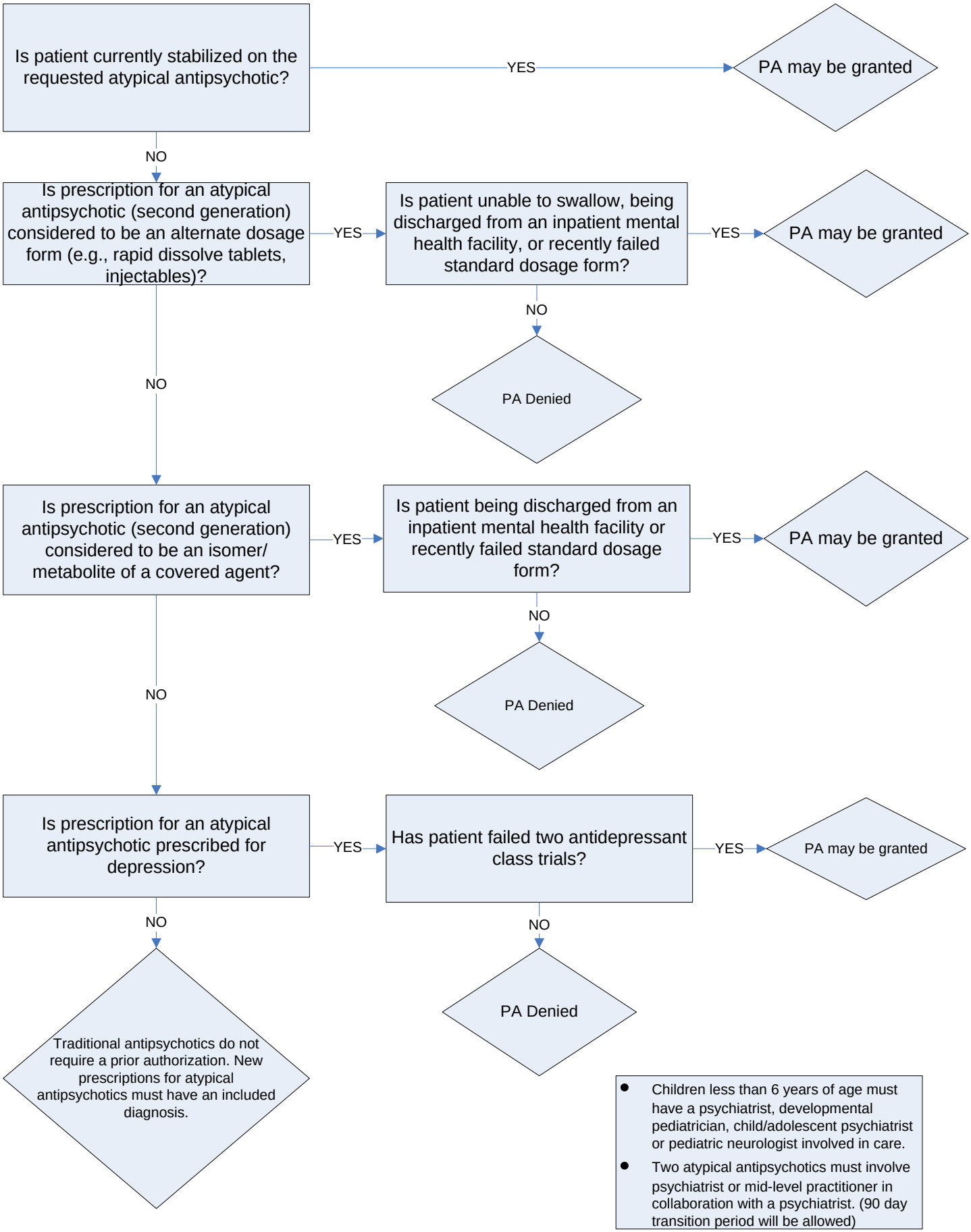
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Atypical Antipsychotics Authorization Criteria



- Children less than 6 years of age must have a psychiatrist, developmental pediatrician, child/adolescent psychiatrist or pediatric neurologist involved in care.
- Two atypical antipsychotics must involve psychiatrist or mid-level practitioner in collaboration with a psychiatrist. (90 day transition period will be allowed)

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, Atacand/HCT, Avapro, Avalide, Benicar, Benicar/HCT, Diovan, Diovan/HCT, Edarbi, Hyzaar, Micardis, Micardis/HCT, Teveten, Teveten/HCT.

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

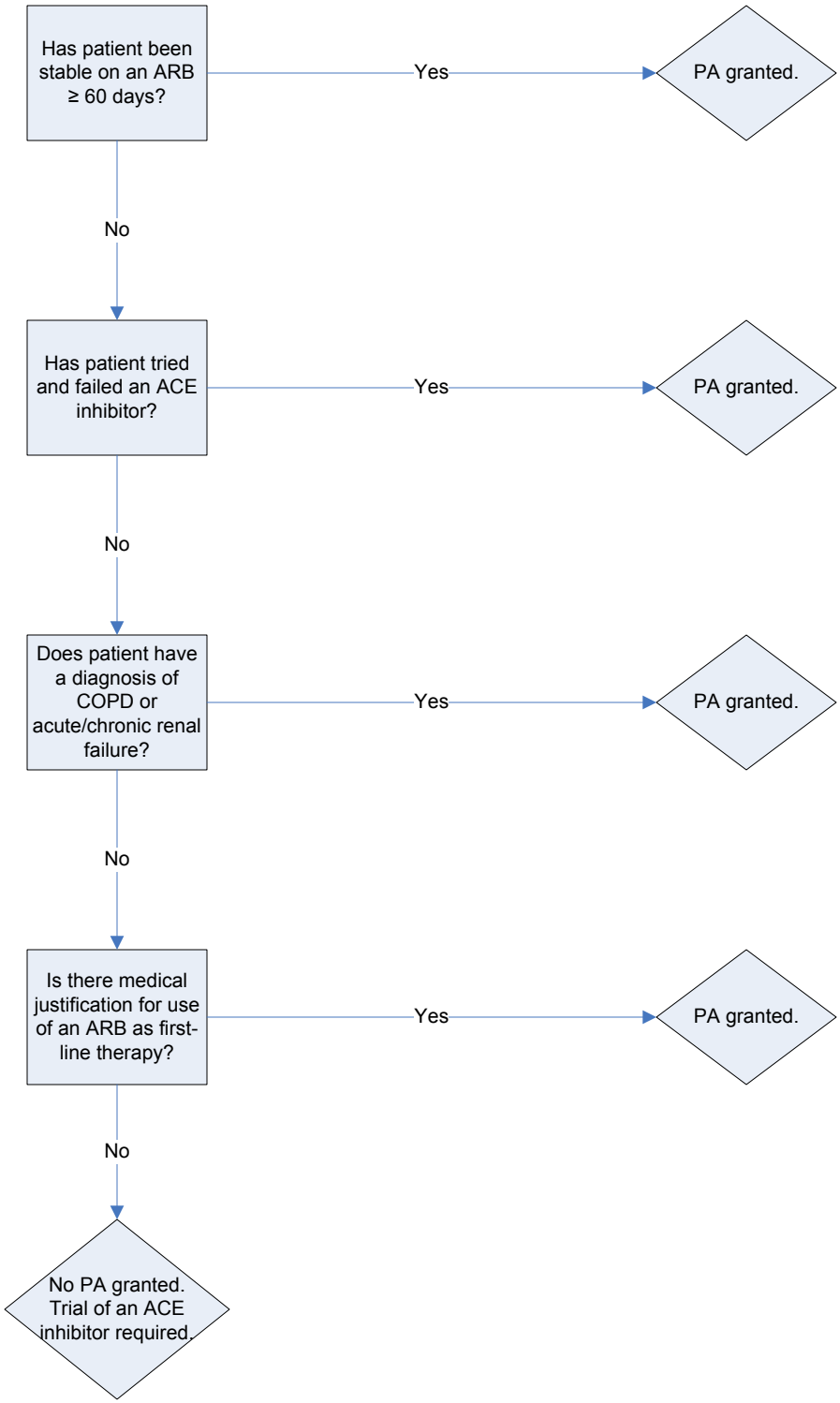
PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services

ARB Authorization Criteria Algorithm



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:	

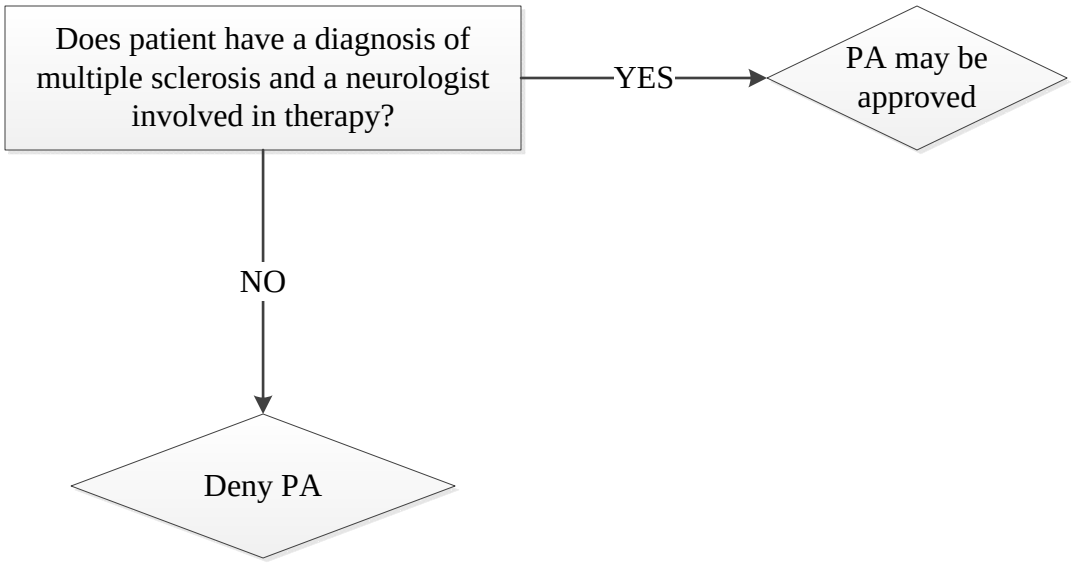
Part IV: PHARMACY INFORMATION

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)

South Dakota Department of Social Services
Aubagio Authorization Algorithm



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:

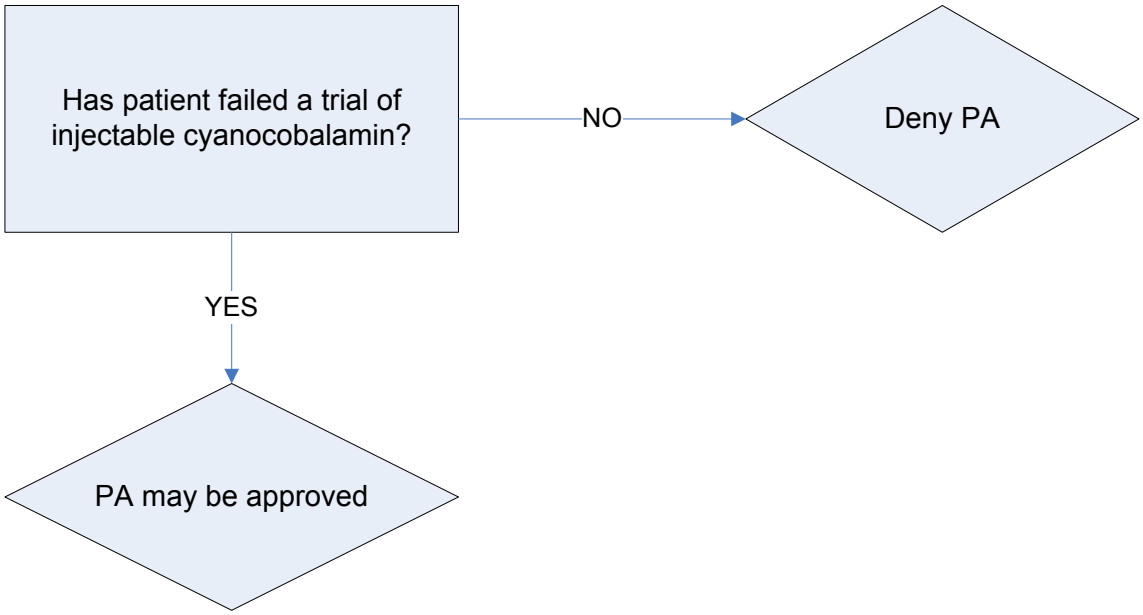
Part IV: PHARMACY INFORMATION

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)					

South Dakota Department of Social Services
Calomist and Nascobal Prior Authorization Algorithm



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

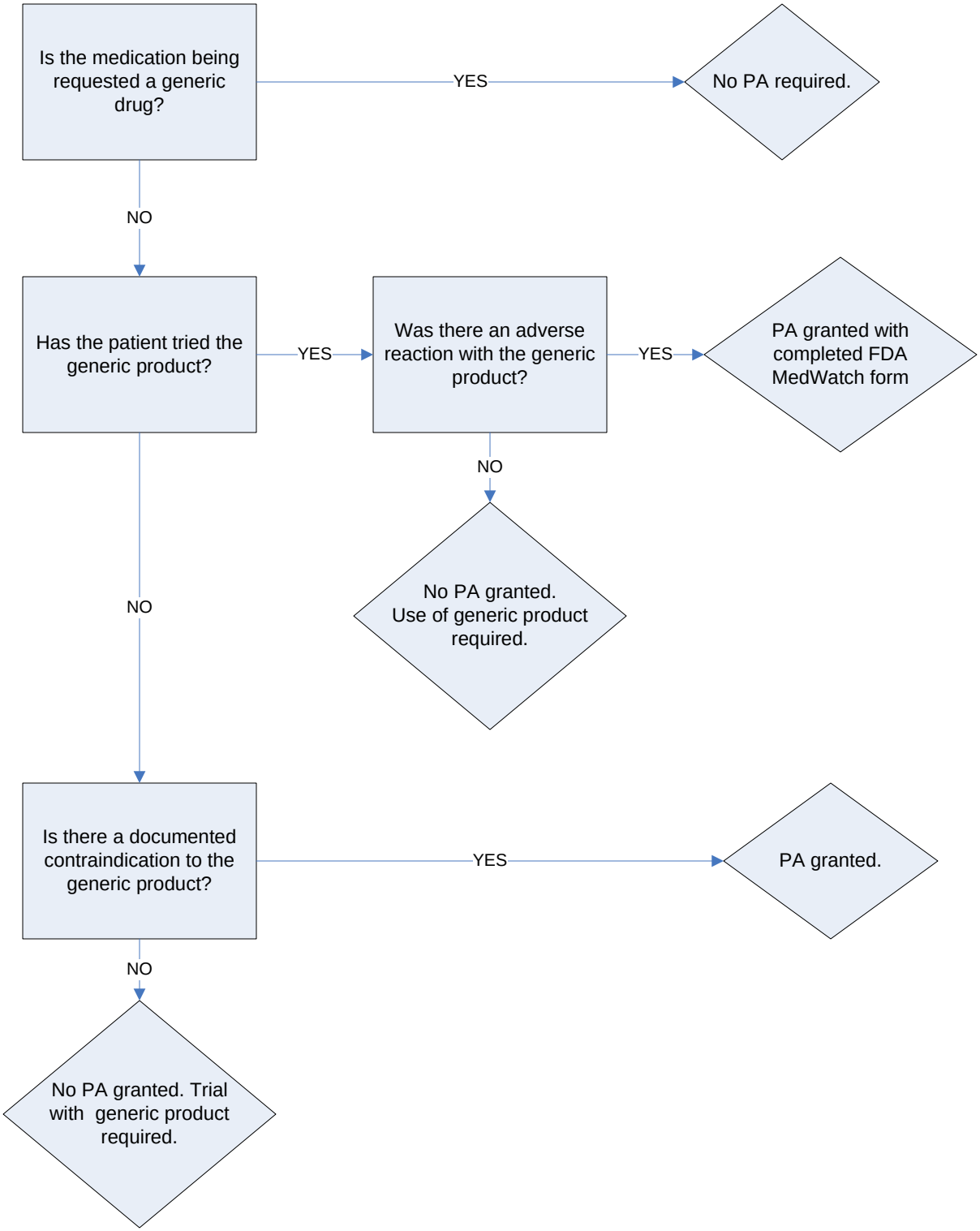
PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services

Dispense As Written Authorization Criteria Algorithm



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:

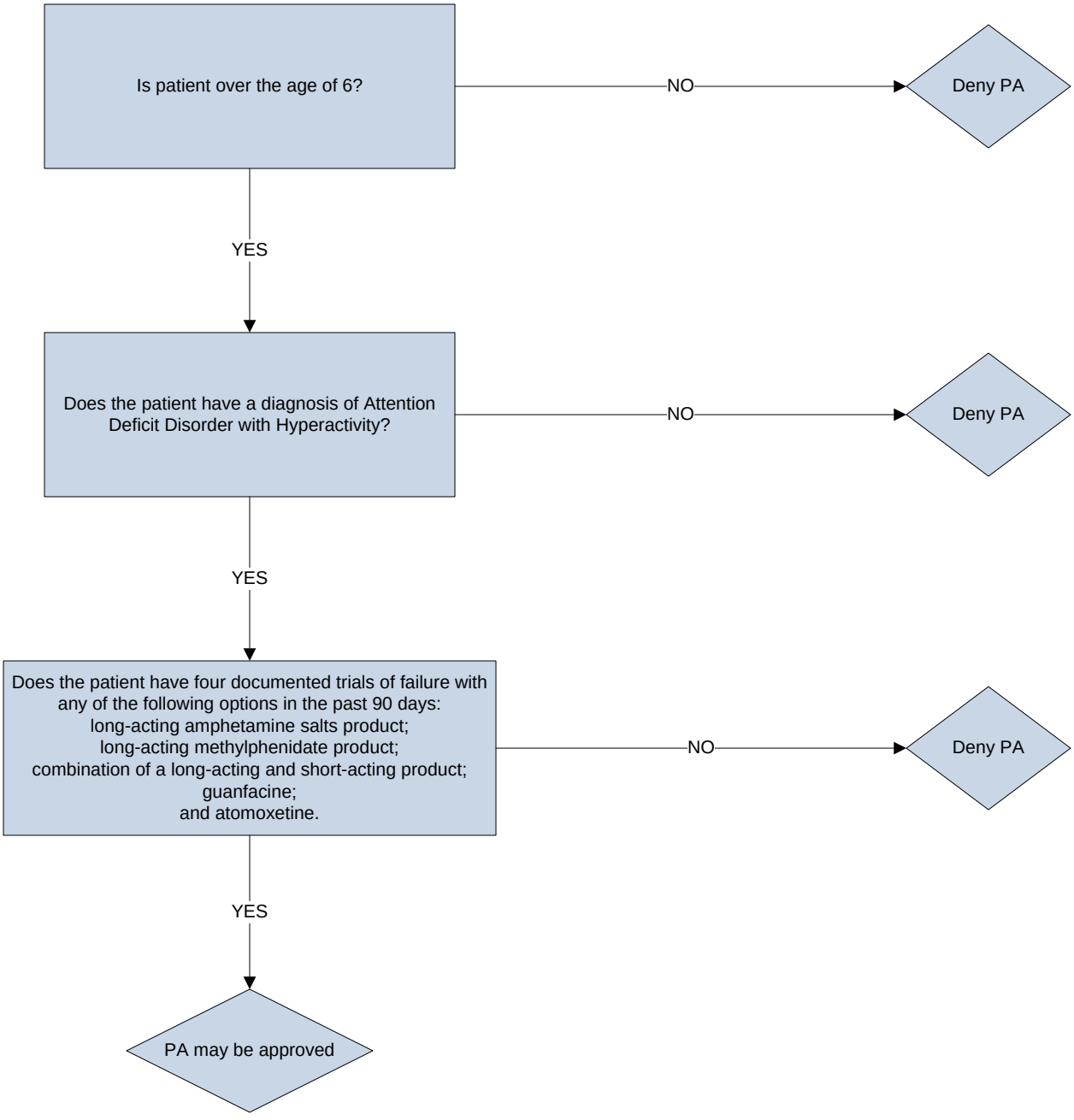
Part IV: TO BE COMPLETED BY PHARMACY

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)	

South Dakota Department of Social Services
Desoxyn Prior Authorization Criteria



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:	

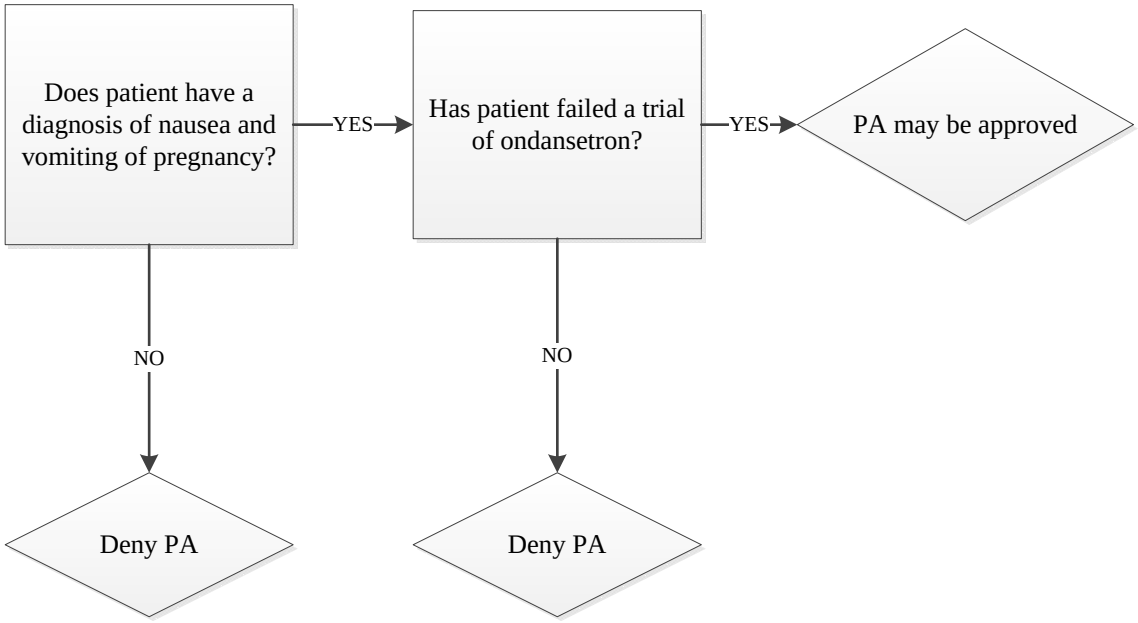
Part IV: PHARMACY INFORMATION

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)

South Dakota Department of Social Services
Diclegis Authorization Algorithm



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:

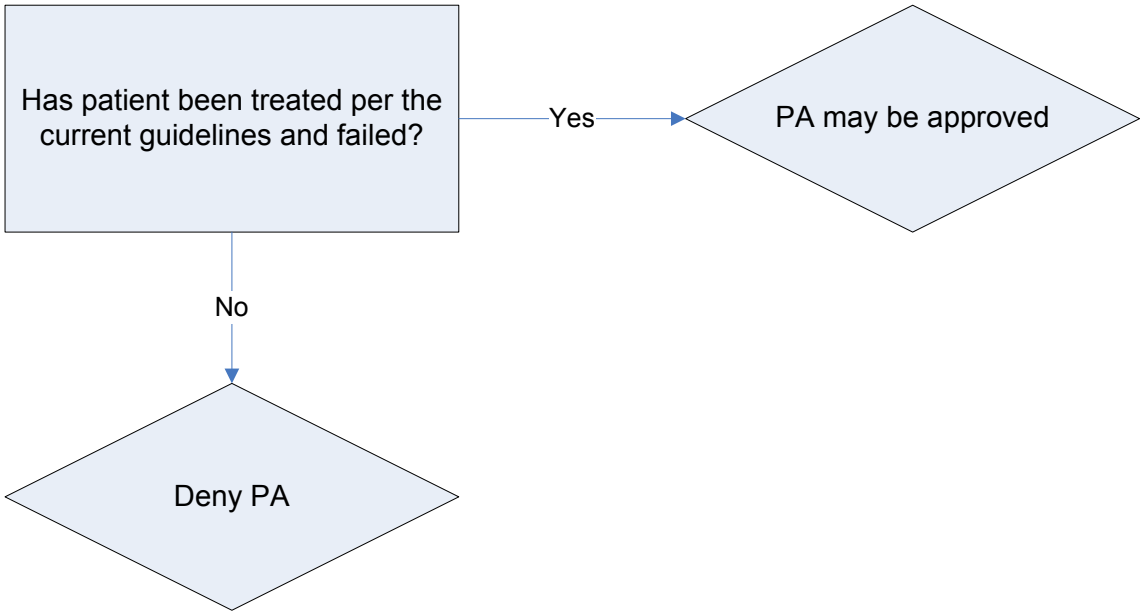
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Dificid Prior Authorization Algorithm



- Patient must have diagnosis of *Clostridium difficile*-associated diarrhea (CDAD)
- Patient must be ≥ 18 years of age
- Patient must have been treated per the current guidelines and failed:
  - Initial episode (mild to moderate severity)-metronidazole
  - Initial episode (severe)-vancomycin*
  - Initial episode (severe, complicated)-vancomycin* and metronidazole)
  - First recurrence-same regimen as first episode
  - Second recurrence-oral vancomycin* in tapered regimen

*Compounded oral vancomycin is covered without prior authorization
*Metronidazole is covered without prior authorization

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:

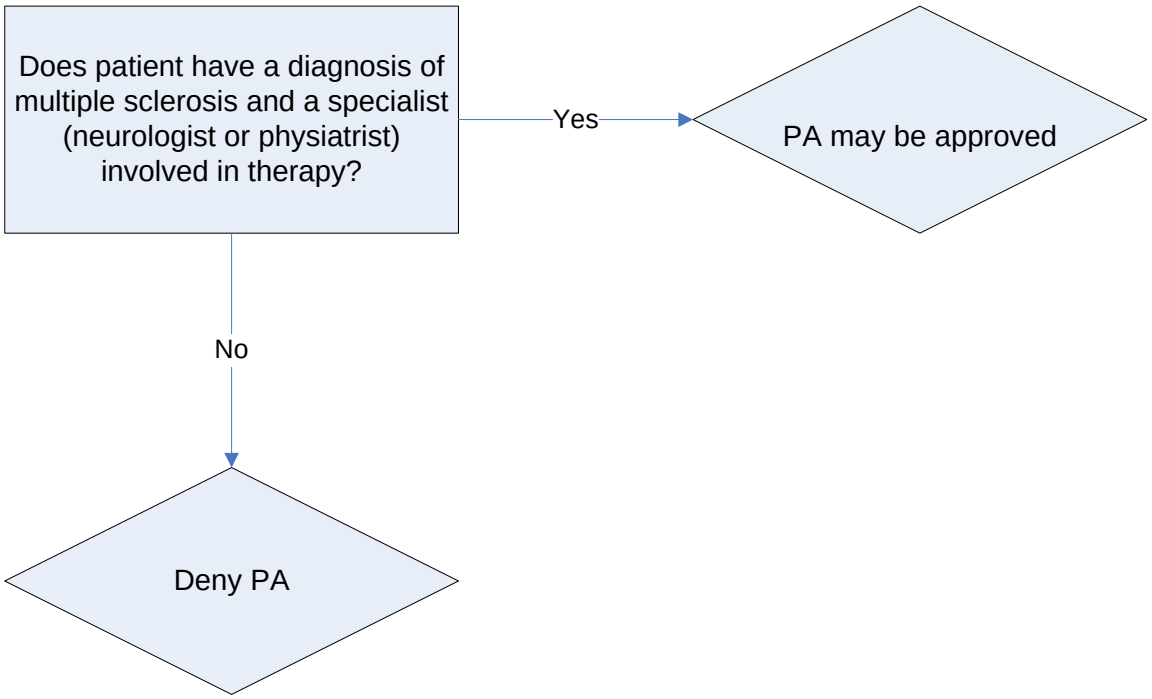
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Extavia Prior Authorization Algorithm



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:

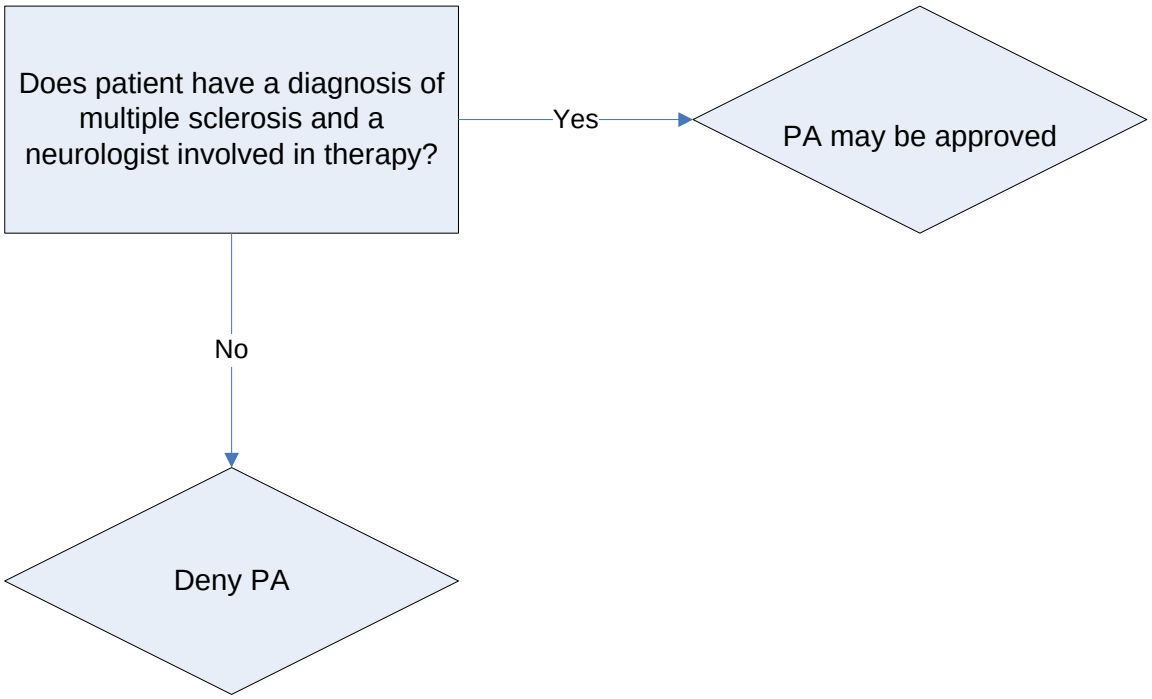
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Gilenya Prior Authorization Algorithm



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:

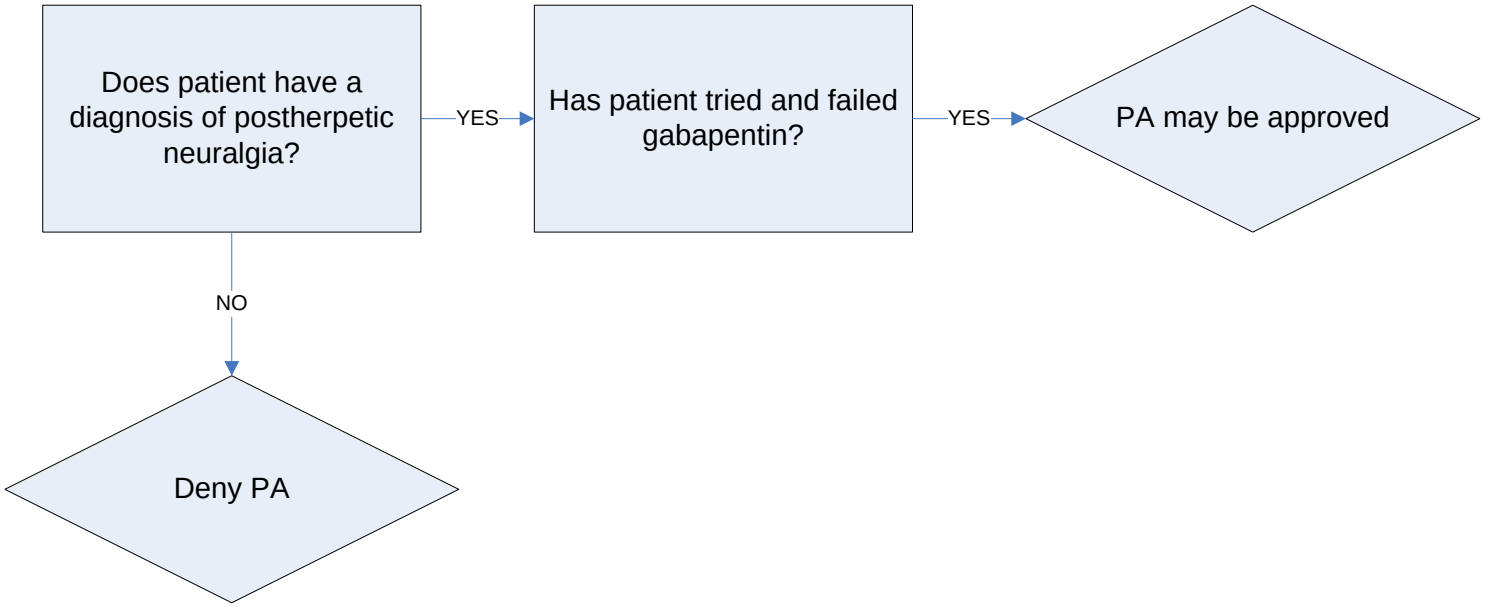
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Gralise Prior Authorization Algorithm



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**	Failed therapy (Drug and Dose)
□ **Detrol**	□ **Sanctura**	
□ **Vesicare**	□ **Sanctura XR**	Start Date: End Date:

PHYSICIAN SIGNATURE: DATE:

Part IV: PHARMACY INFORMATION

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

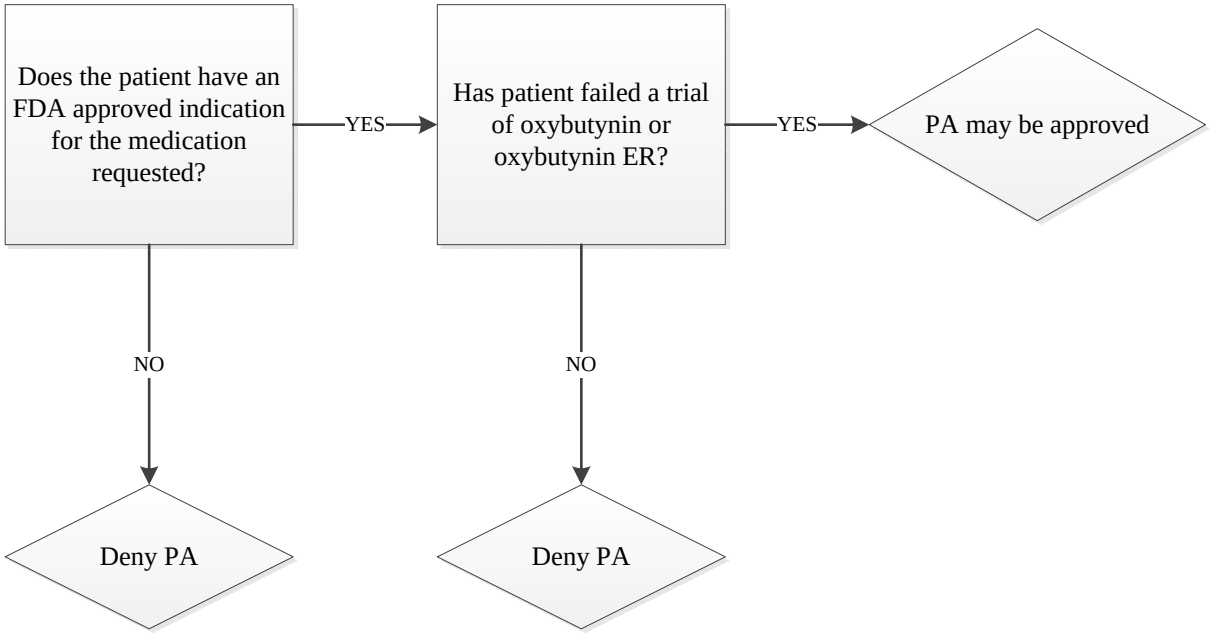
Part V: FOR OFFICIAL USE ONLY

Date: / / Initials: _____

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

Denied: (Reasons)

South Dakota Department of Social Services
Genitourinary Smooth Muscle Relaxants
Authorization Algorithm



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:		

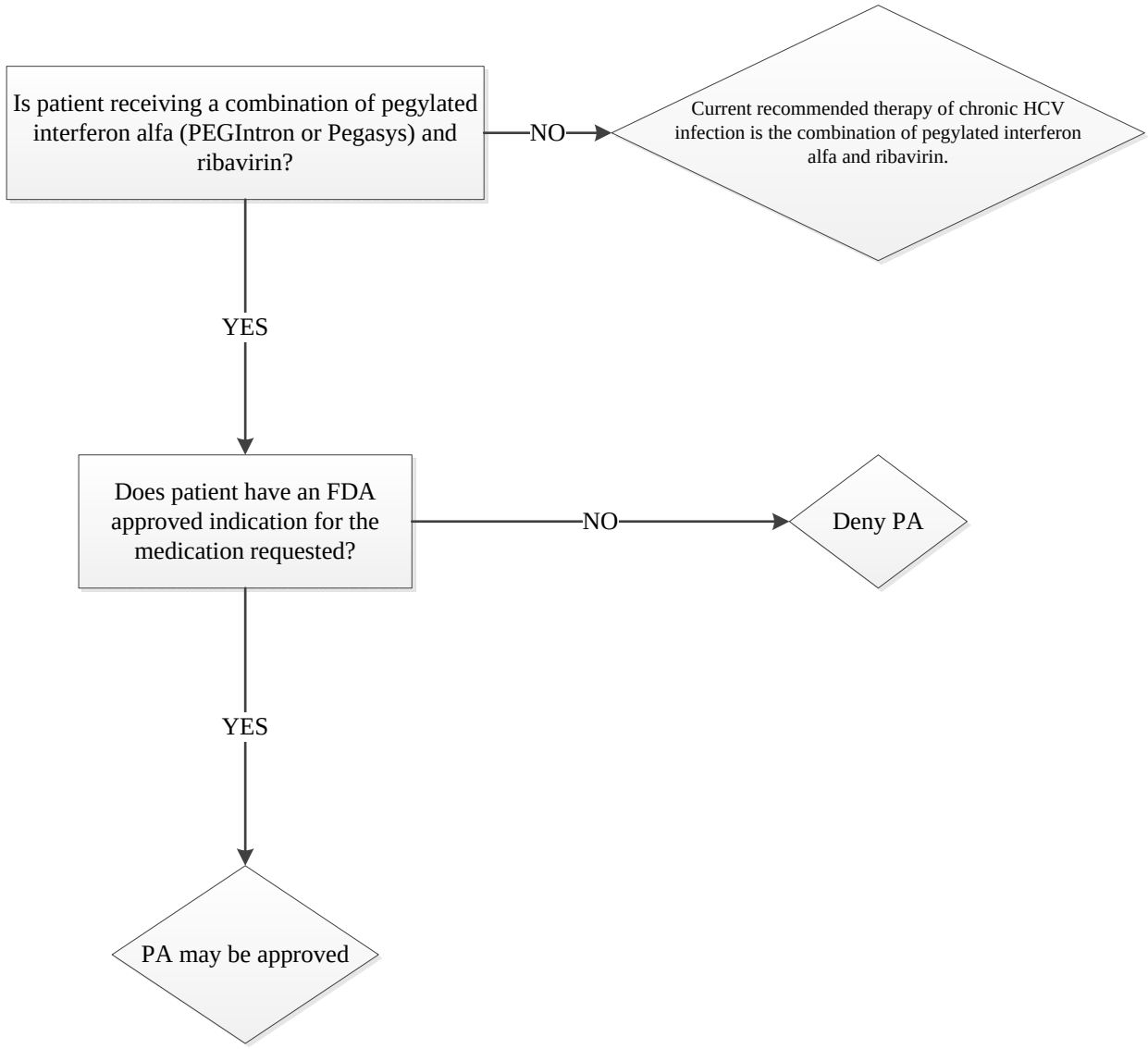
Part IV: PHARMACY INFORMATION

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)

South Dakota Department of Social Services
Hepatitis C Virus (HCV) Medication Authorization Algorithm



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:

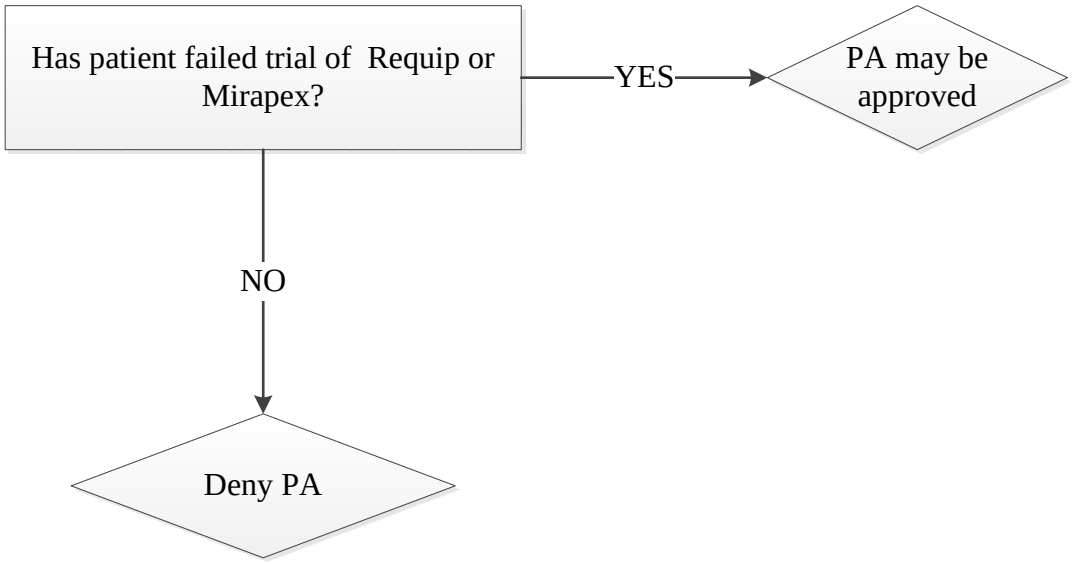
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Horizant Authorization Algorithm



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:

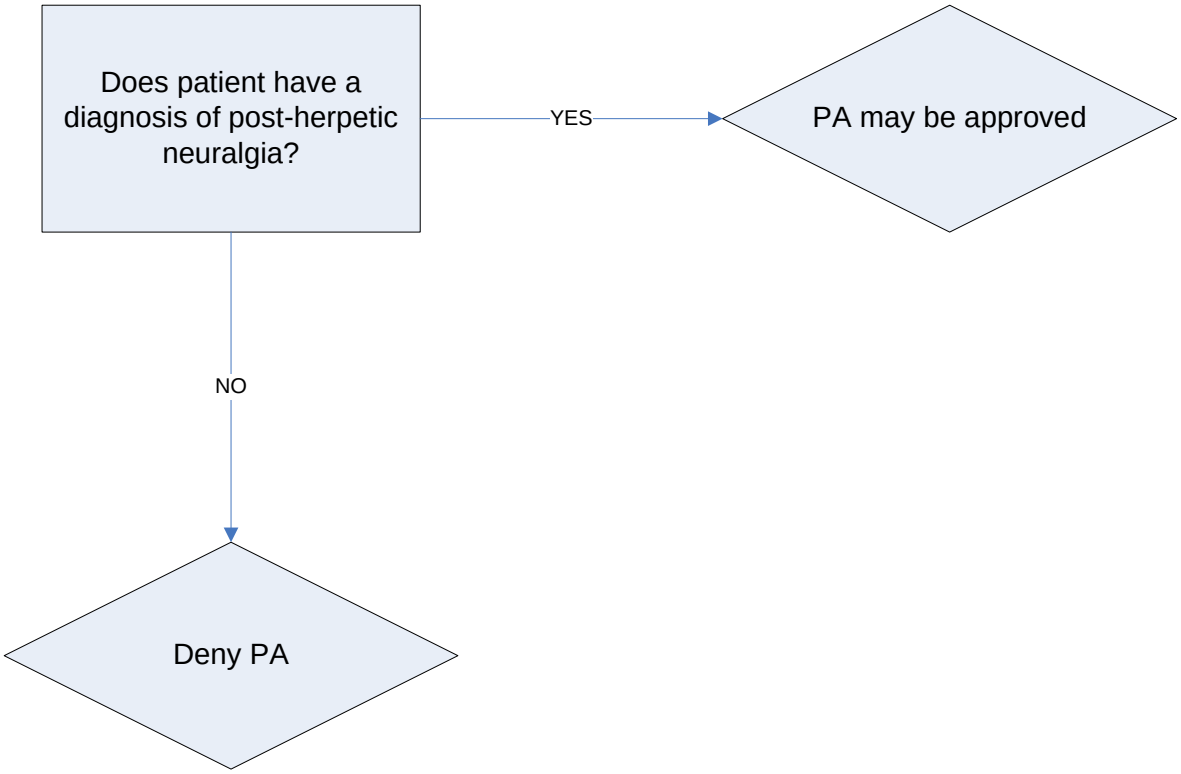
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Lidoderm Prior Authorization Algorithm



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:

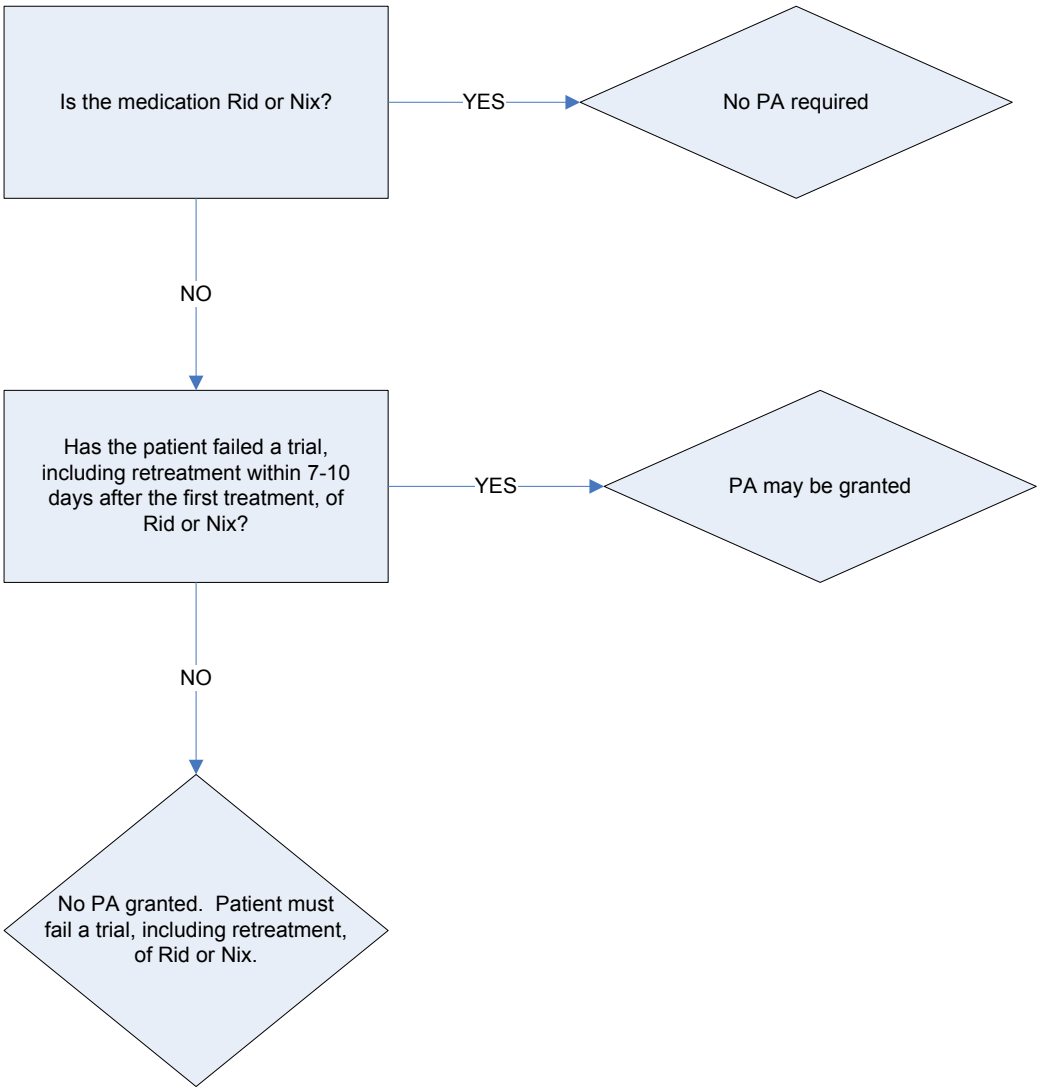
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Lindane and Malathion Prior Authorization Criteria



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:

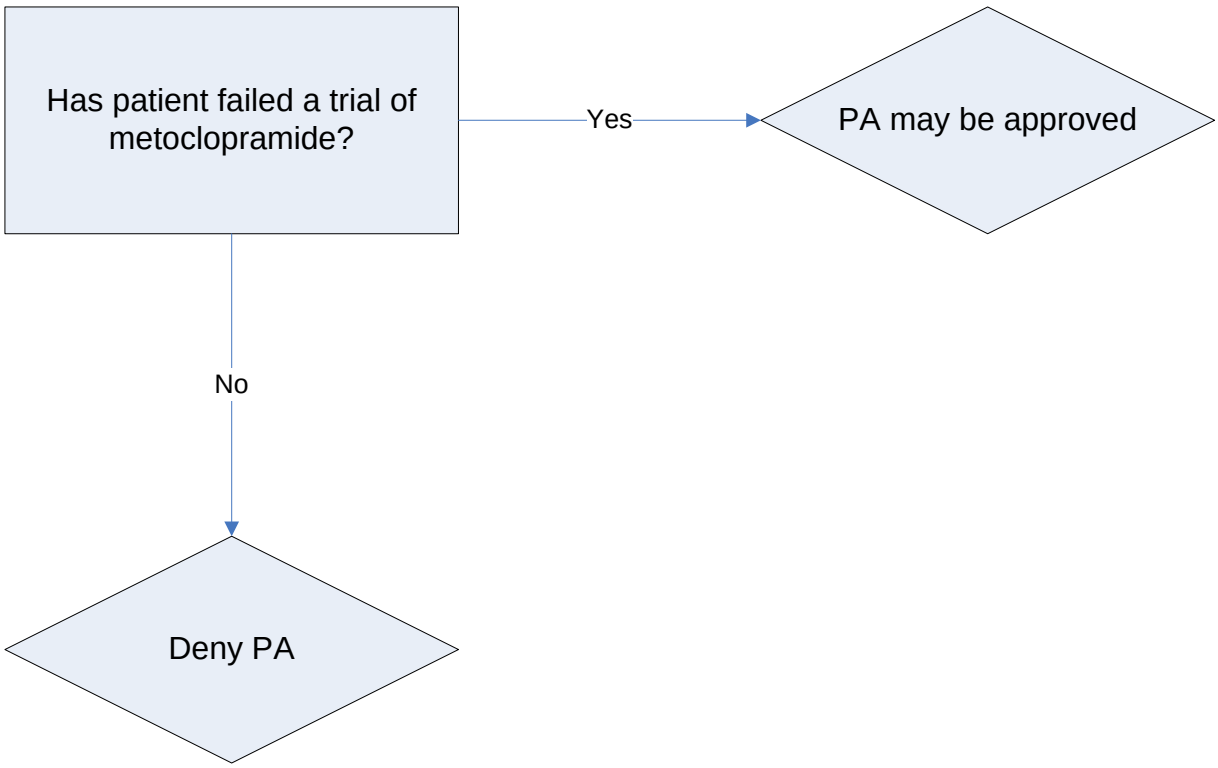
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Metozolv Prior Authorization Criteria



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:

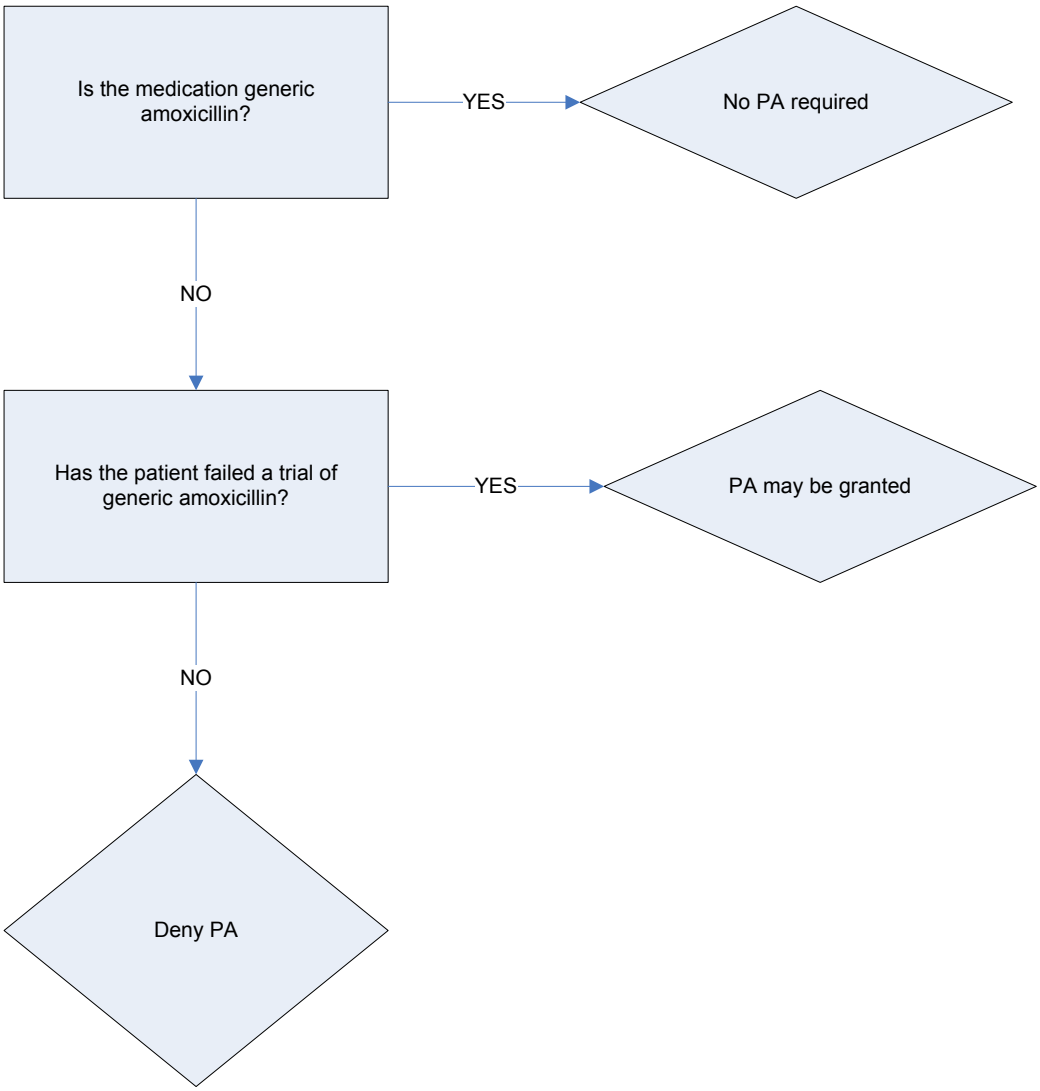
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Moxatag Prior Authorization Criteria



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 □ OPANA □ KADIAN □ AVINZA □ EXALGO □ FENTORA

□ BUTRANS □ ABSTRAL □ COMBUNOX □ ONSOLIS □ MAGNACET

Qualifications for coverage:

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

Physician Signature:	Date:

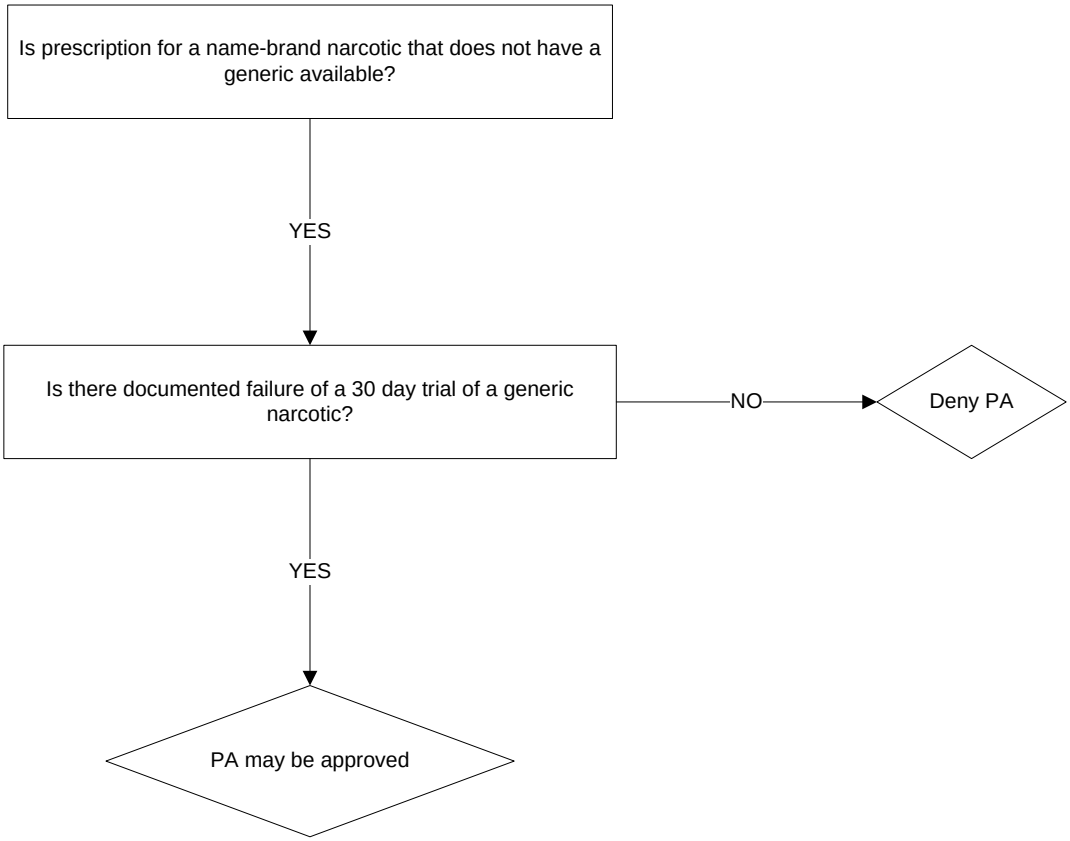
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Brand-Name Narcotics PA Form



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:	

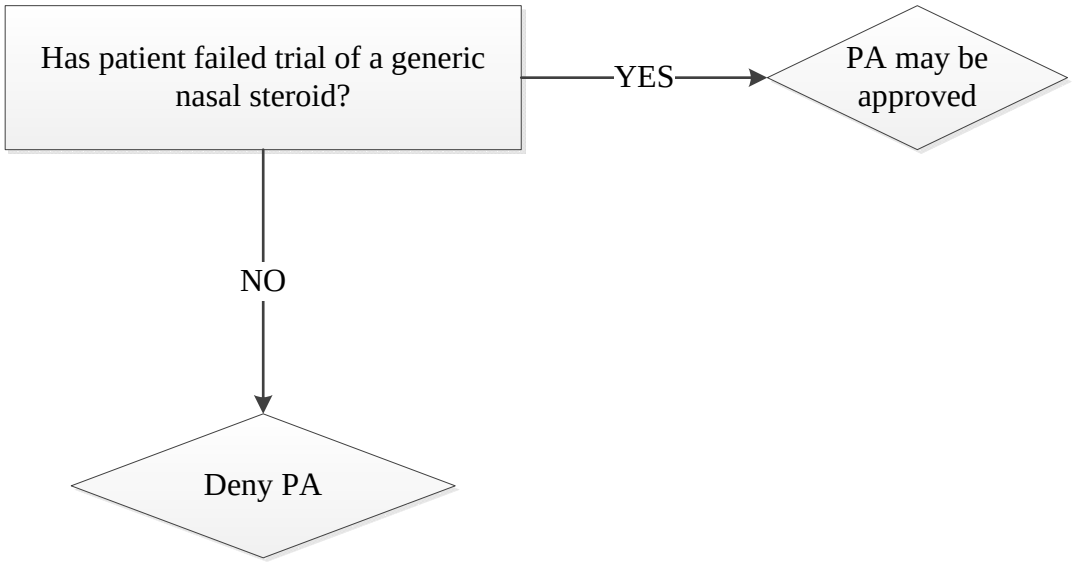
Part IV: PHARMACY INFORMATION

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)

South Dakota Department of Social Services
Nasal Steroids Authorization Algorithm



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:

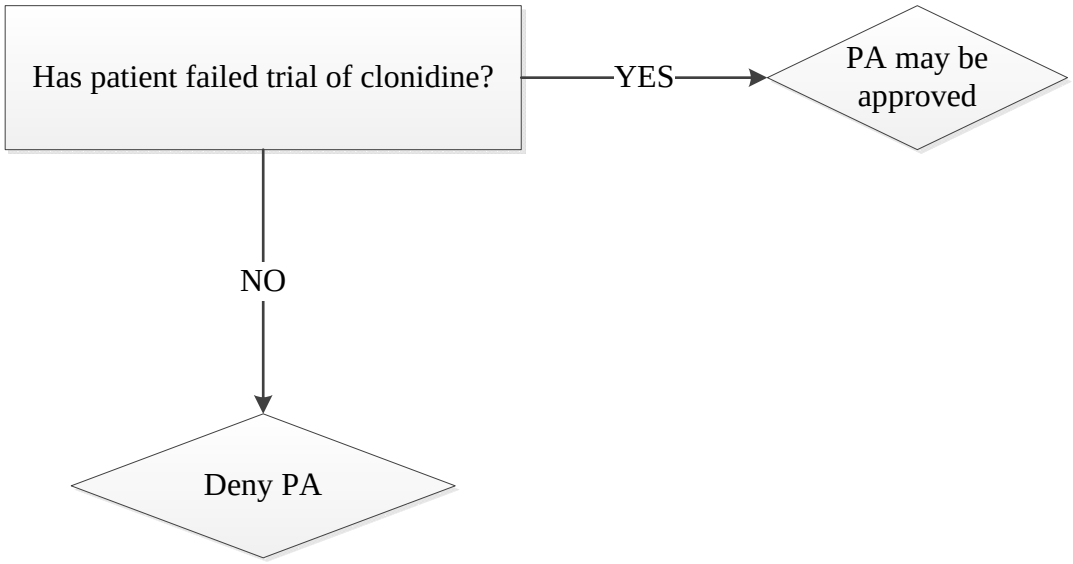
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Nexiclon Authorization Algorithm



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:

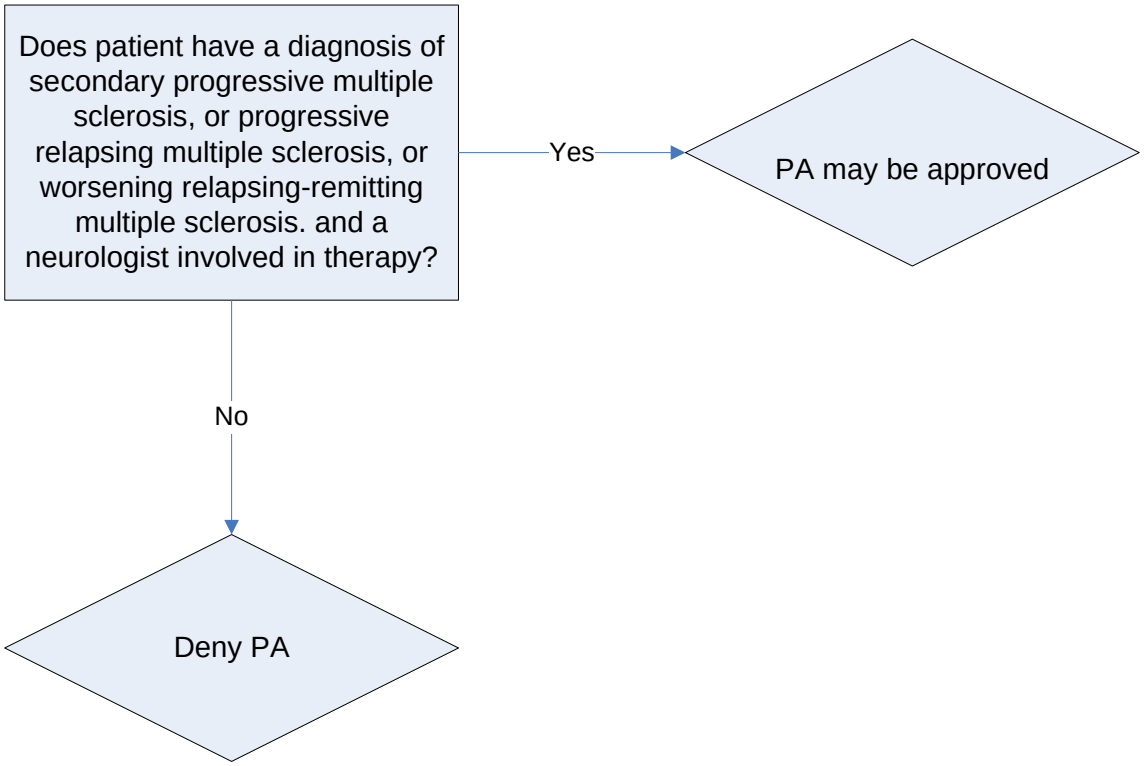
Part IV: PHARMACY INFORMATION

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)

South Dakota Department of Social Services
Novantrone Prior Authorization Algorithm



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:

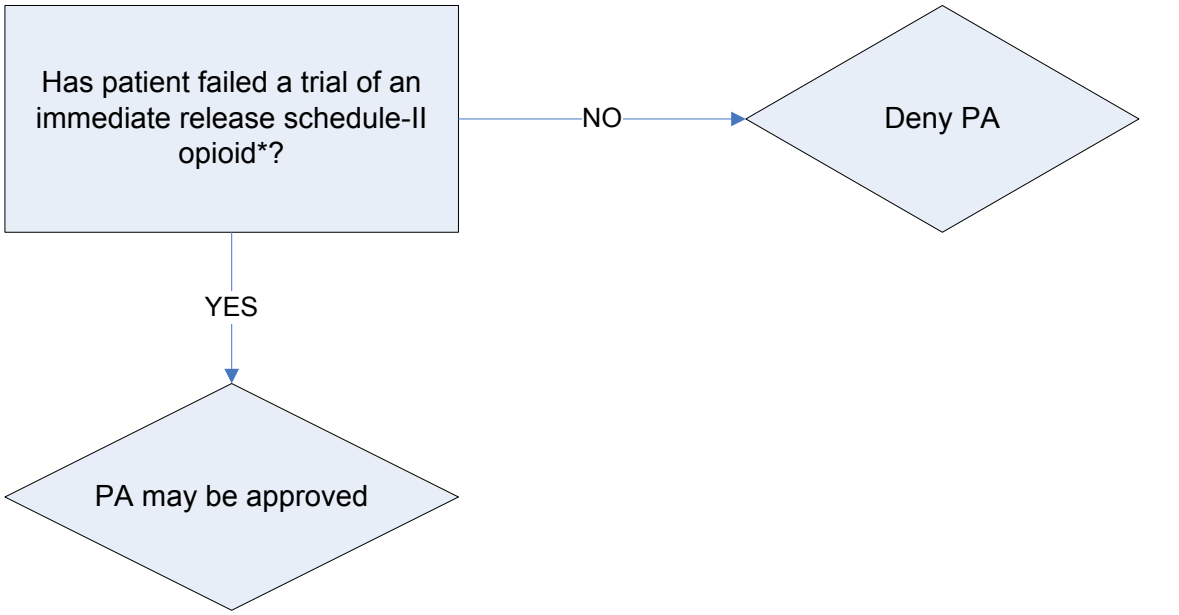
Part IV: PHARMACY INFORMATION

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)					

South Dakota Department of Social Services
Nucynta Prior Authorization Algorithm



*Immediate release oxycodone, oxymorphone, hydromorphone and meperidine do not require a prior authorization.

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

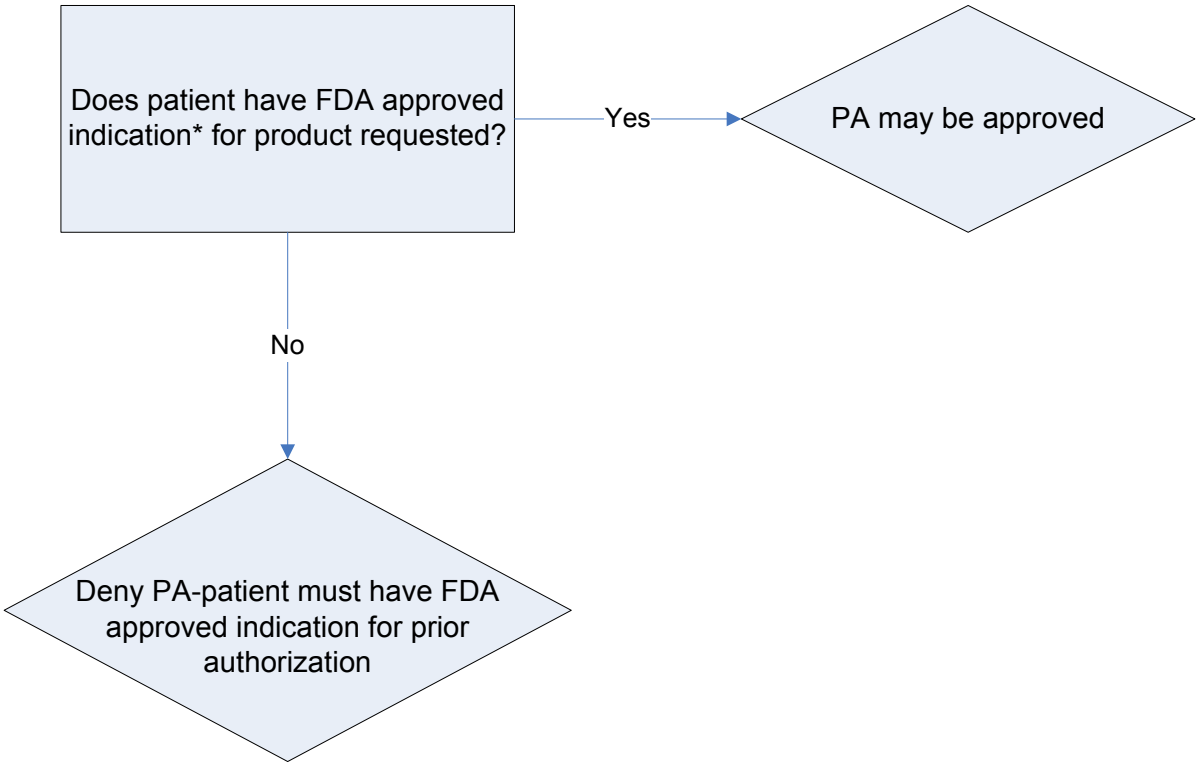
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Nuvigil and Provigil Prior Authorization Algorithm



*FDA indications for Nuvigil and Provigil include:
1. Narcolepsy
2. Excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome
3. Shift work sleep disorder

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:

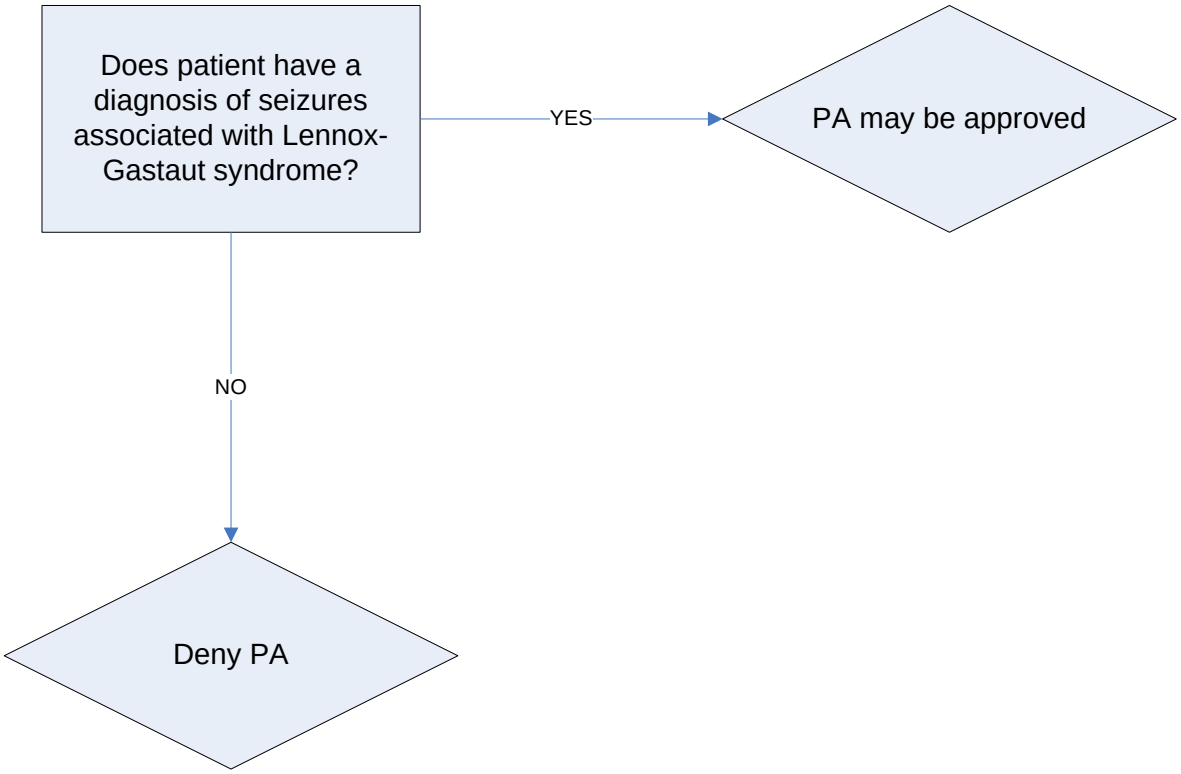
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Onfi Prior Authorization Algorithm



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:

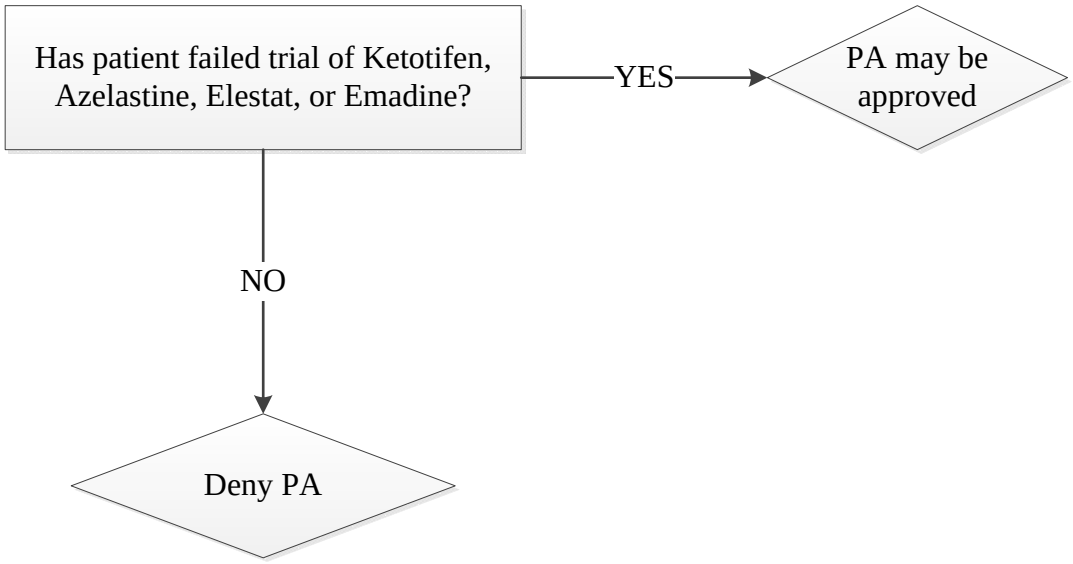
Part IV: PHARMACY INFORMATION

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)

South Dakota Department of Social Services
Ophthalmic Antihistamine Authorization Algorithm



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

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:	

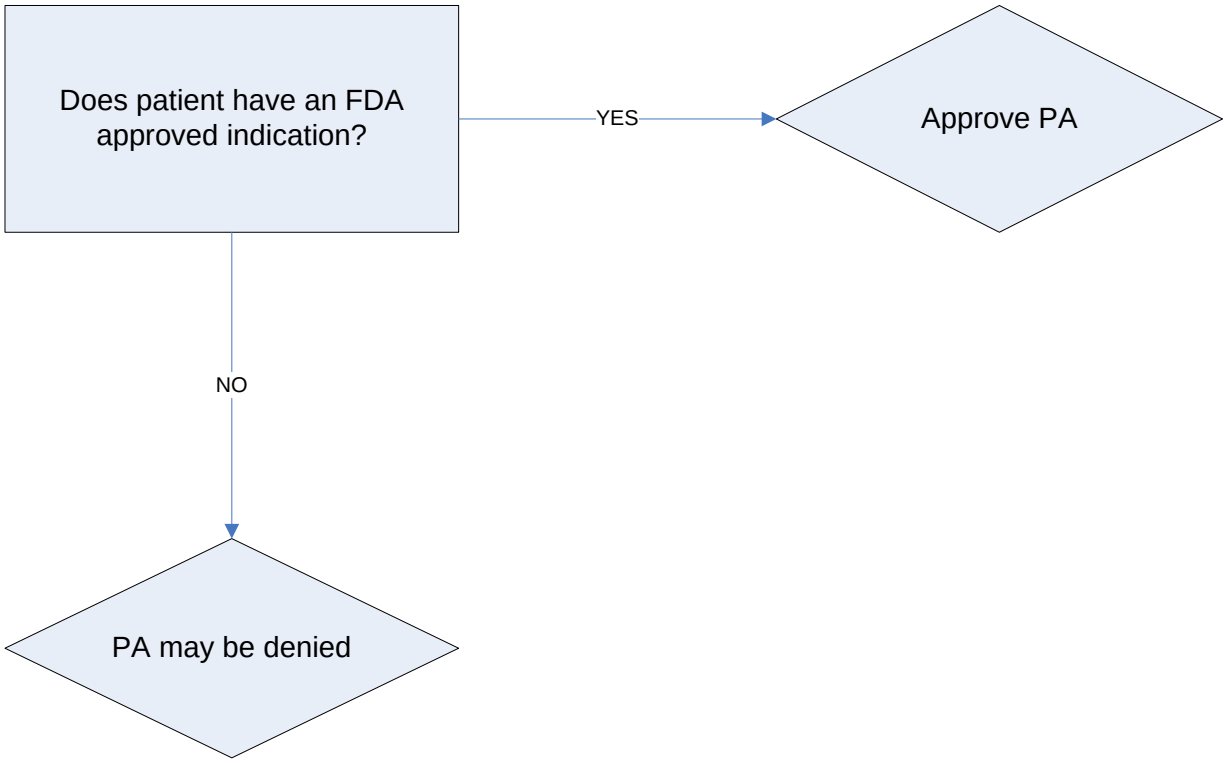
Part IV: PHARMACY INFORMATION

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)

South Dakota Department of Social Services
Oral Anticoagulants Prior Authorization Algorithm



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

ORAVIG
PRIOR AUTHORIZATION
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:

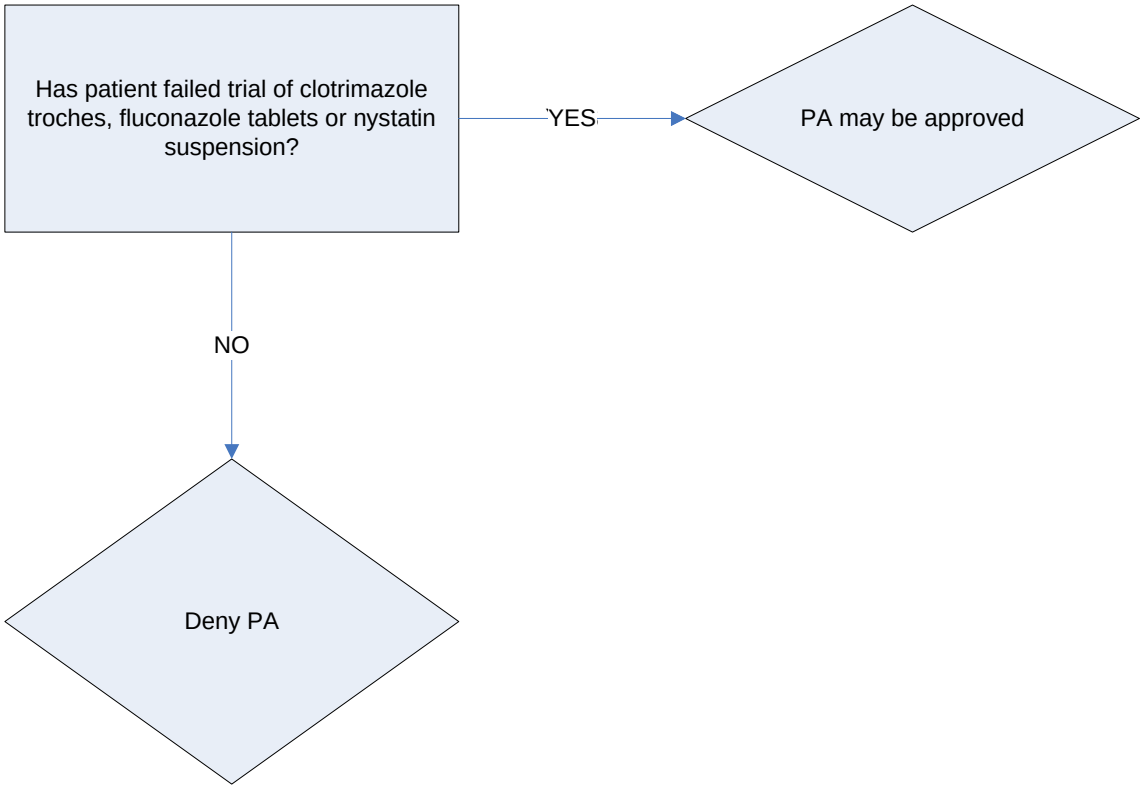
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Oravig Prior Authorization Algorithm



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.

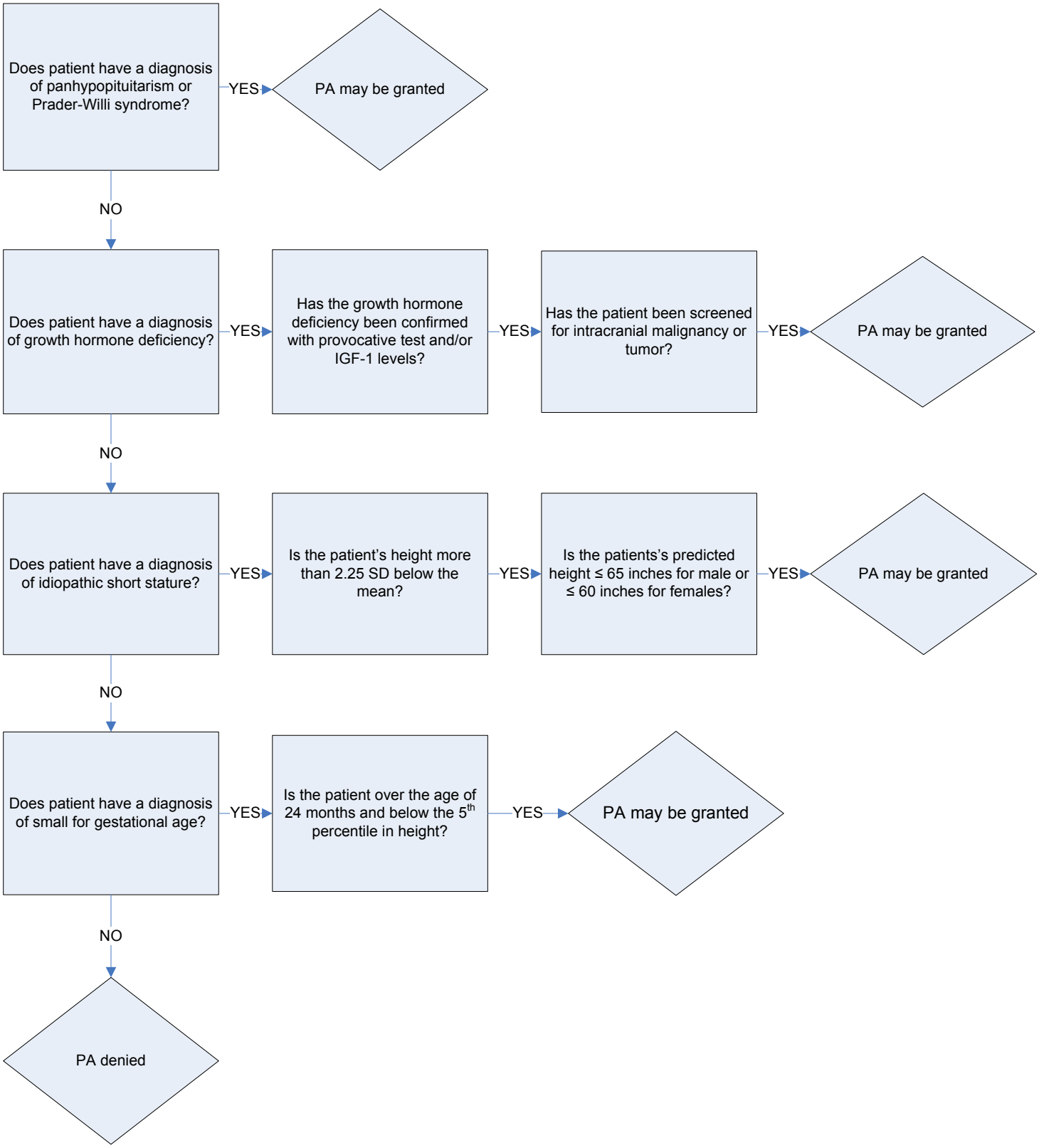
☐ Benign intracranial hypertension ☐ Closed epiphyses ☐ NONE

Physician signature:	Date:

Part IV: PHARMACY INFORMATION

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

South Dakota Department of Social Services
Pediatric Growth Hormone Criteria



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#:

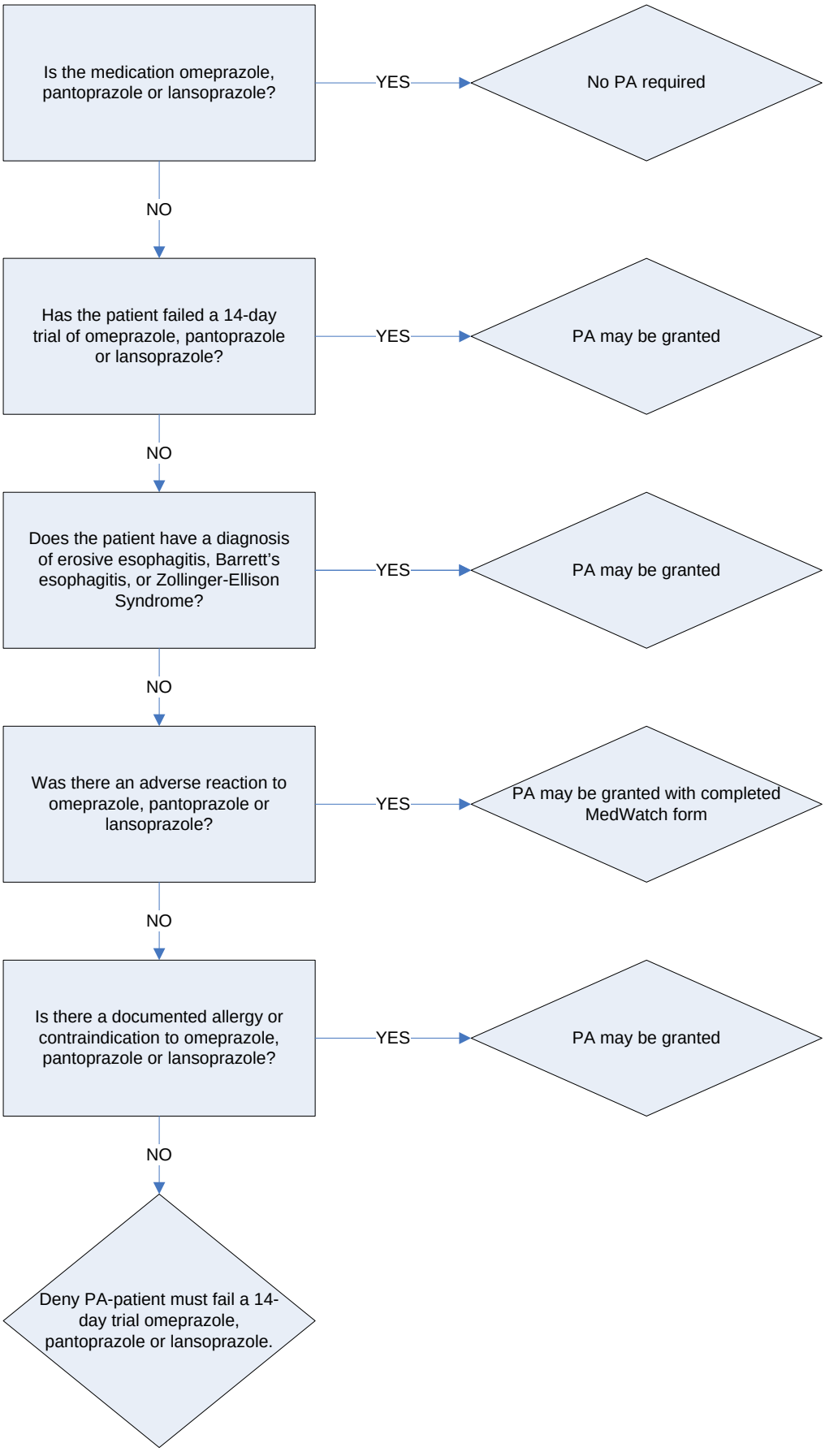
Date: / /

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

Denied (Reasons): To: / /

South Dakota Department of Social Services

Proton Pump Inhibitor Prior Authorization Criteria



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:

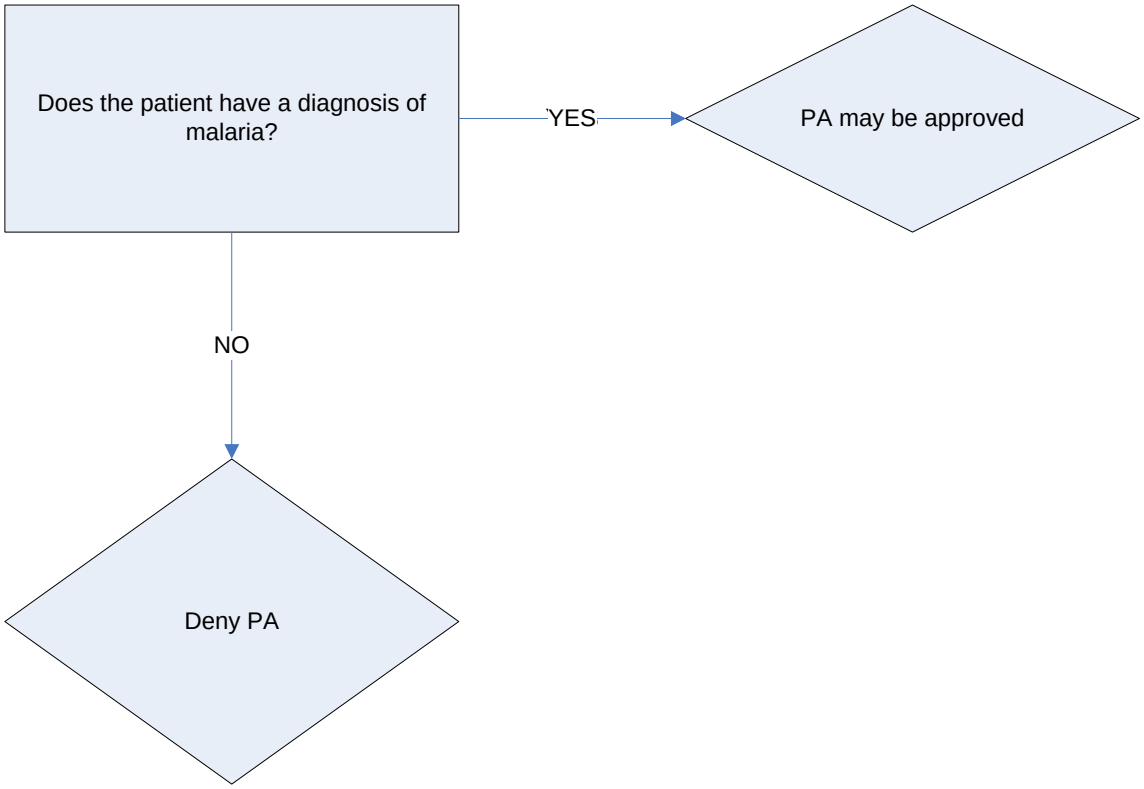
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Qualaquin Prior Authorization Algorithm



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:	

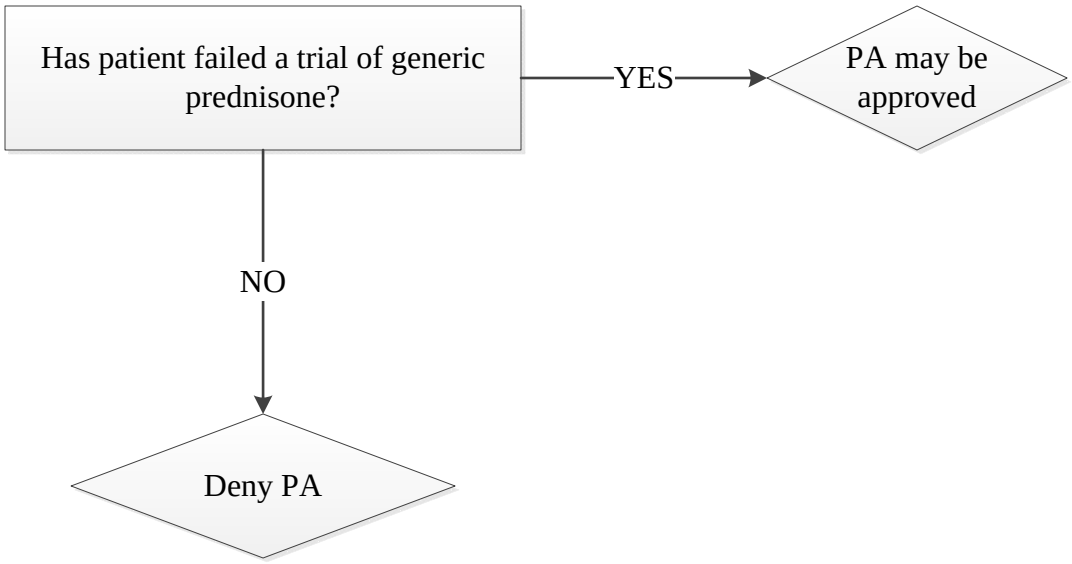
Part IV: PHARMACY INFORMATION

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)

South Dakota Department of Social Services
Rayos Authorization Algorithm



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:	

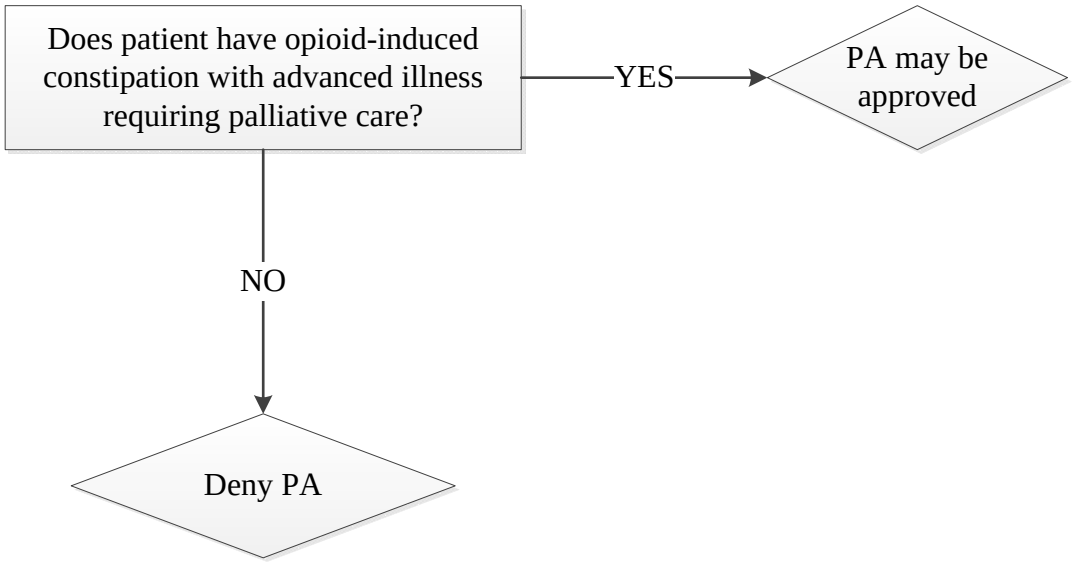
Part IV: PHARMACY INFORMATION

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)

South Dakota Department of Social Services
Relistor Authorization Algorithm



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:

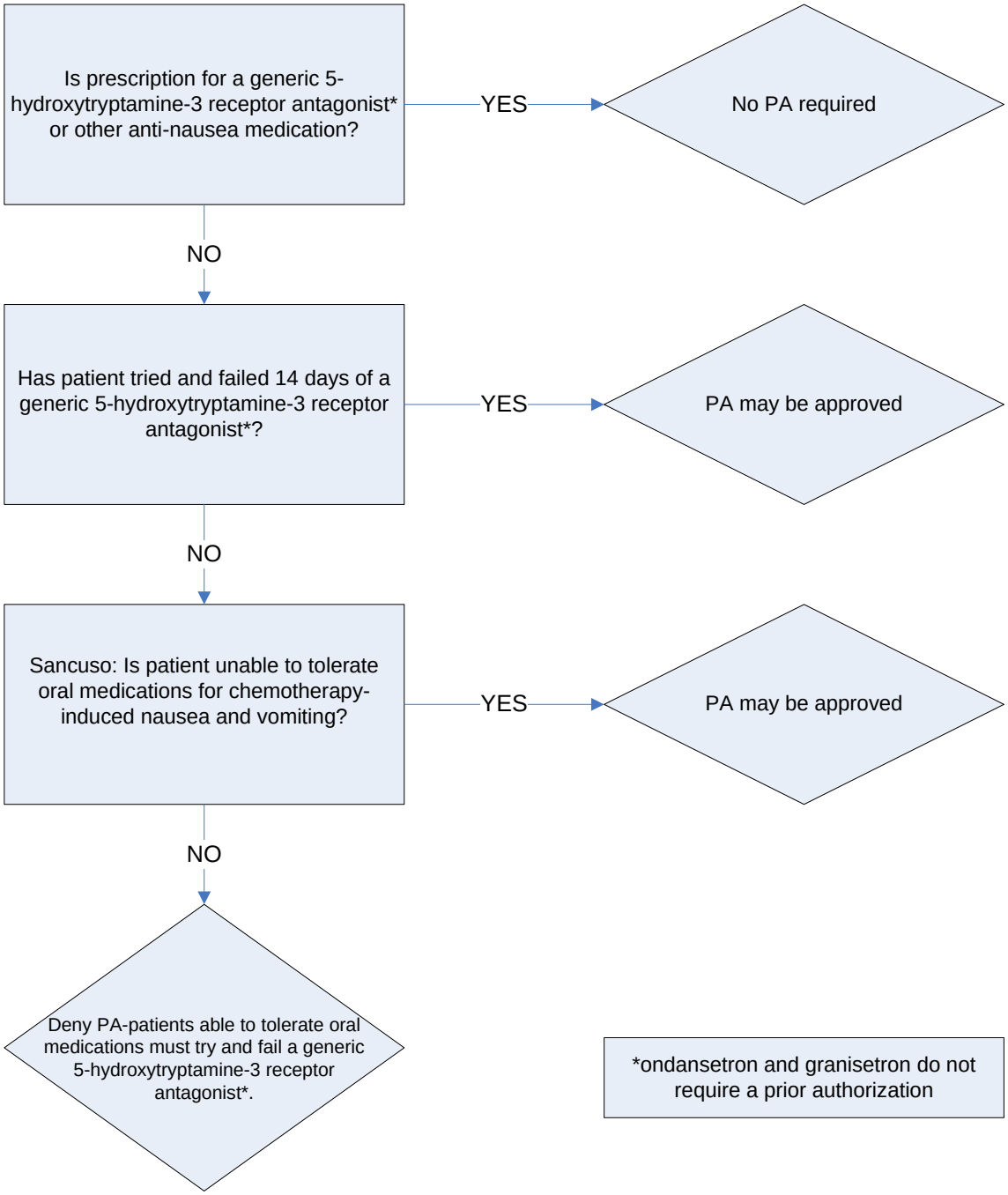
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Sancuso, Granisol, and Zuplenz
Prior Authorization Algorithm



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:

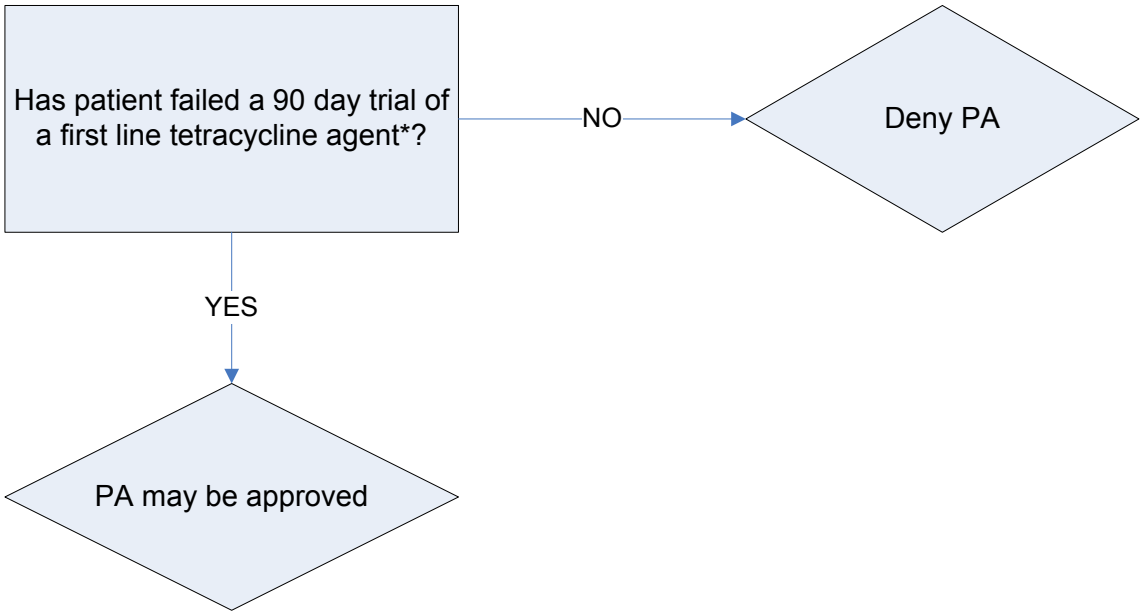
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Solodyn and Oracea Prior Authorization Algorithm



*First line agents include doxycycline, minocycline, and tetracycline.

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:

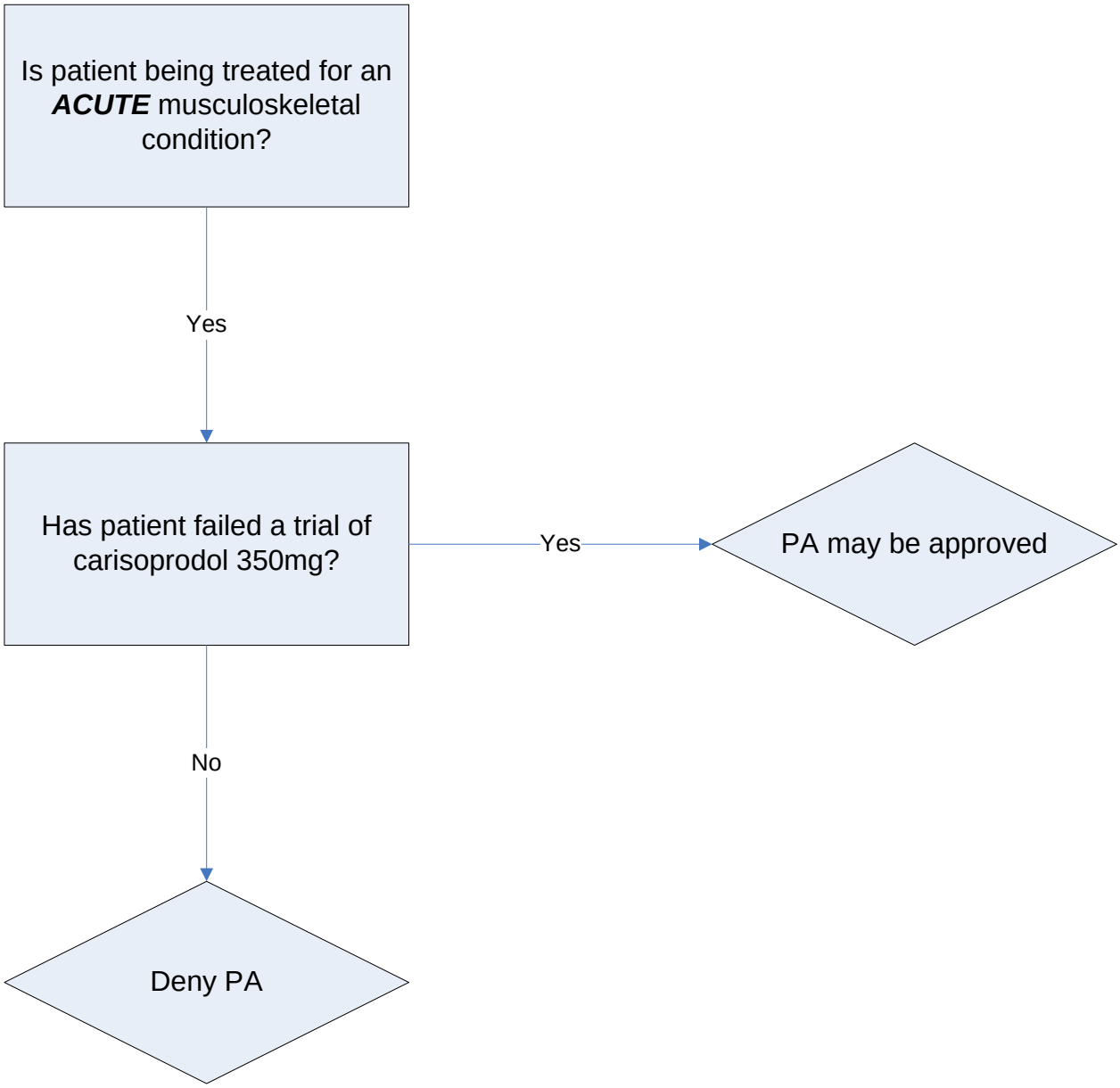
Part IV: TO BE COMPLETED BY PHARMACY

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)	

South Dakota Department of Social Services
Soma 250mg Prior Authorization Criteria



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:

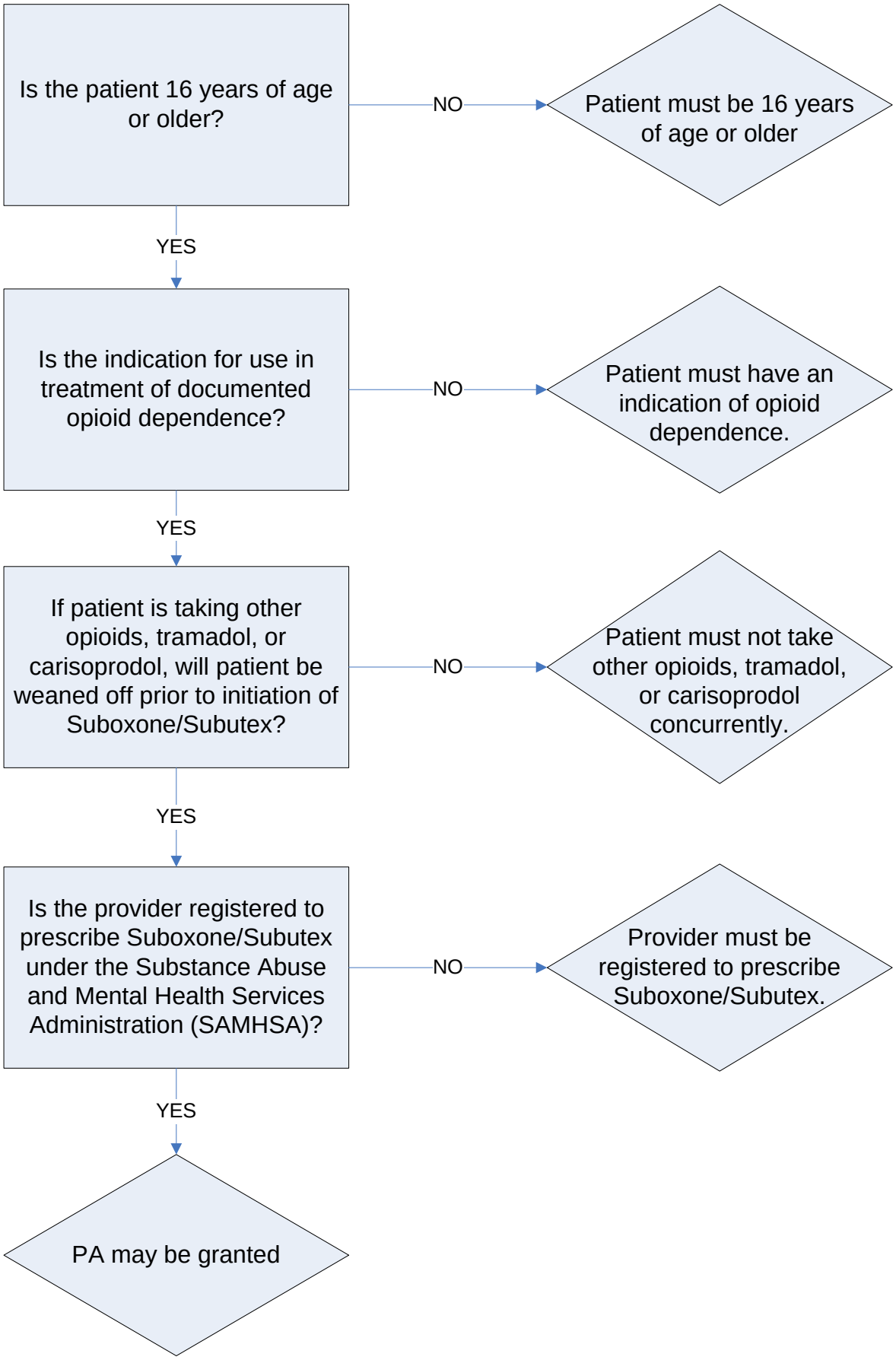
Part IV: TO BE COMPLETED BY PHARMACY

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)	

South Dakota Department of Social Services
Suboxone/Subutex Prior Authorization Criteria



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:

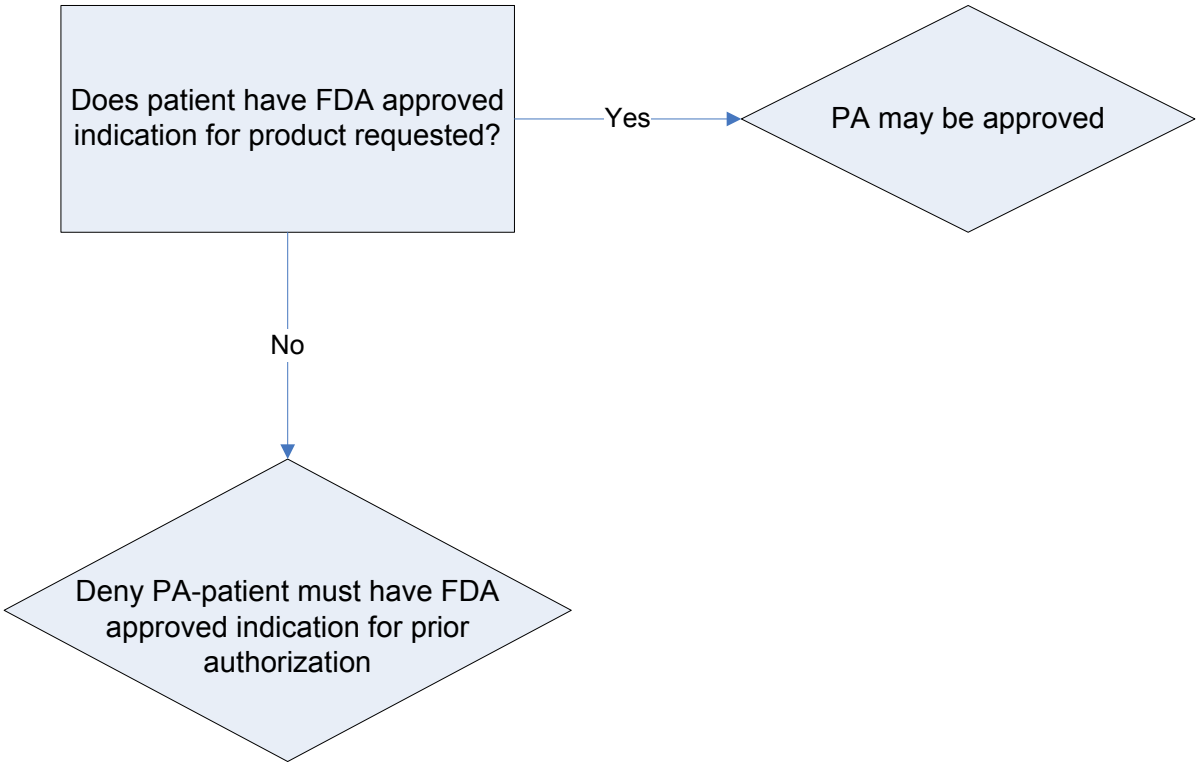
Part IV: PHARMACY INFORMATION

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)		

South Dakota Department of Social Services
Targeted Immune Modulators Authorization Algorithm



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:

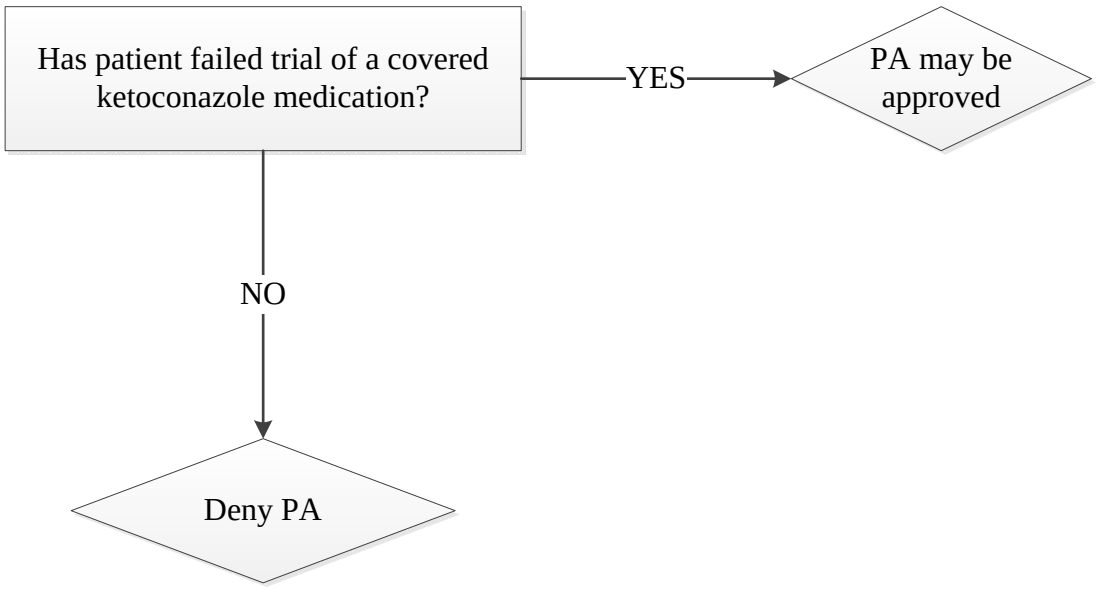
Part IV: PHARMACY INFORMATION

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)

South Dakota Department of Social Services
Topical Ketoconazole Products Authorization Algorithm



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:

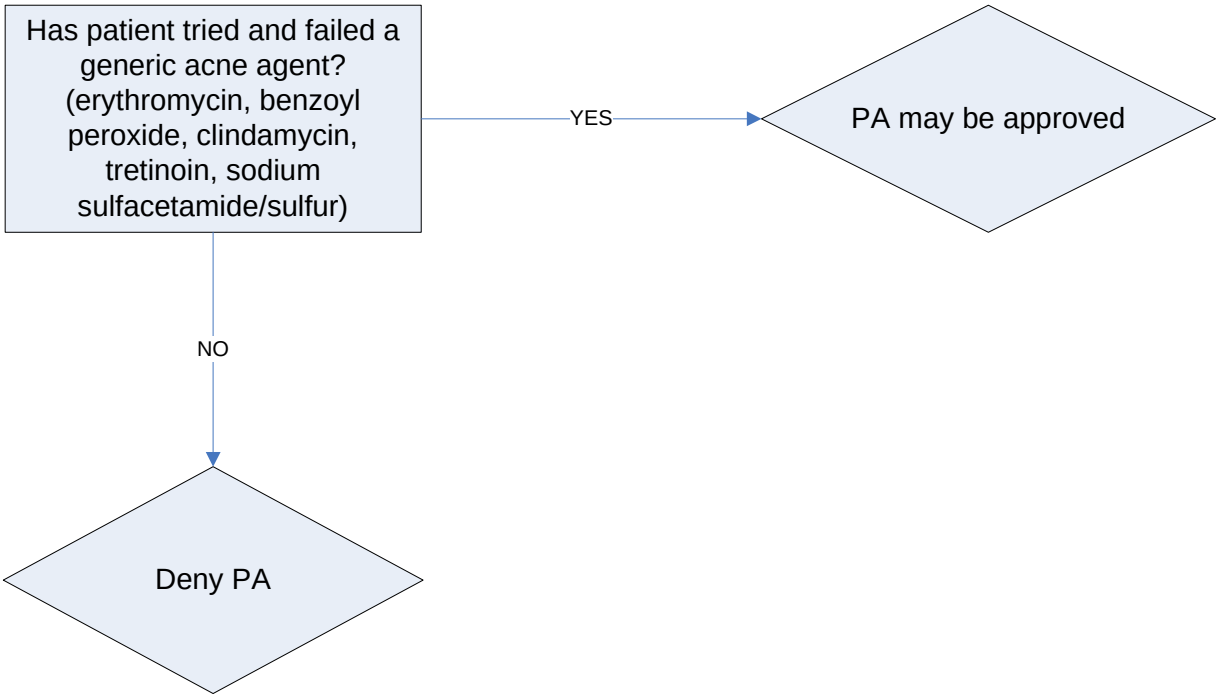
Part IV: PHARMACY INFORMATION

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)

South Dakota Department of Social Services
Topical Acne Agents
Prior Authorization Algorithm



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:

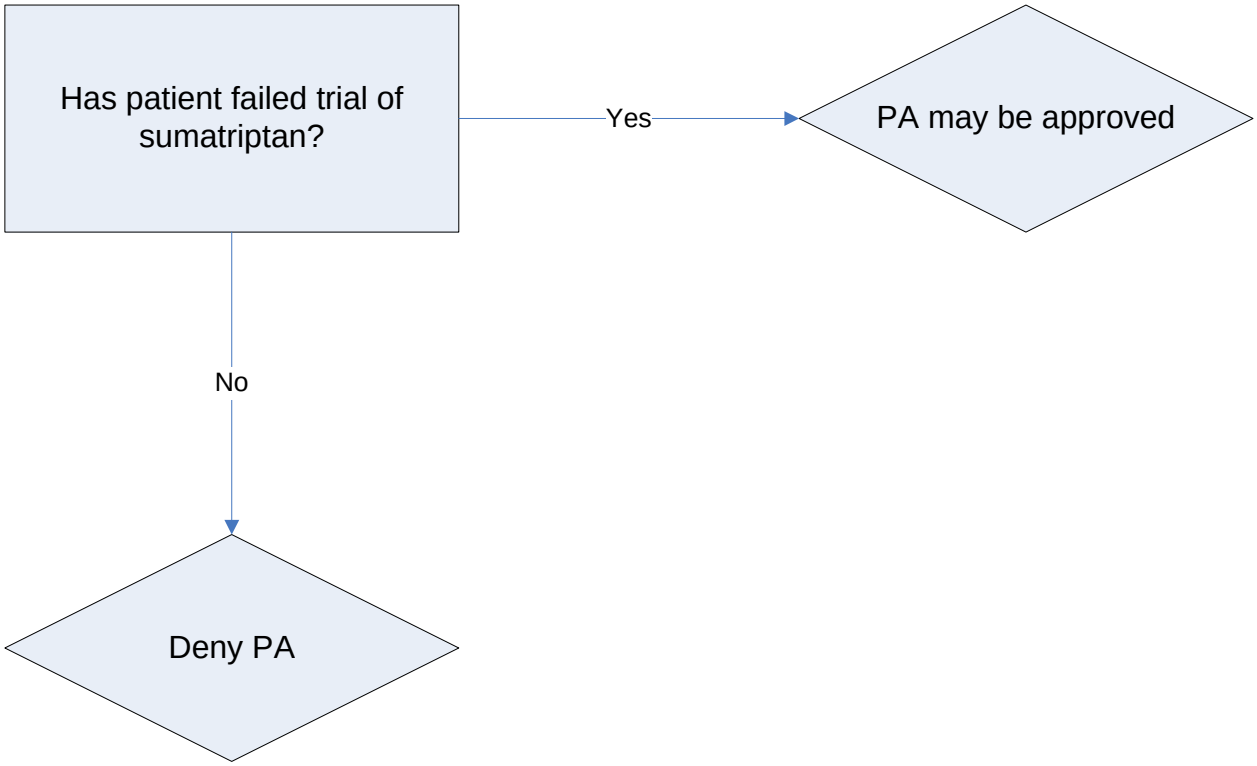
Part IV: PHARMACY INFORMATION

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)	

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



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:

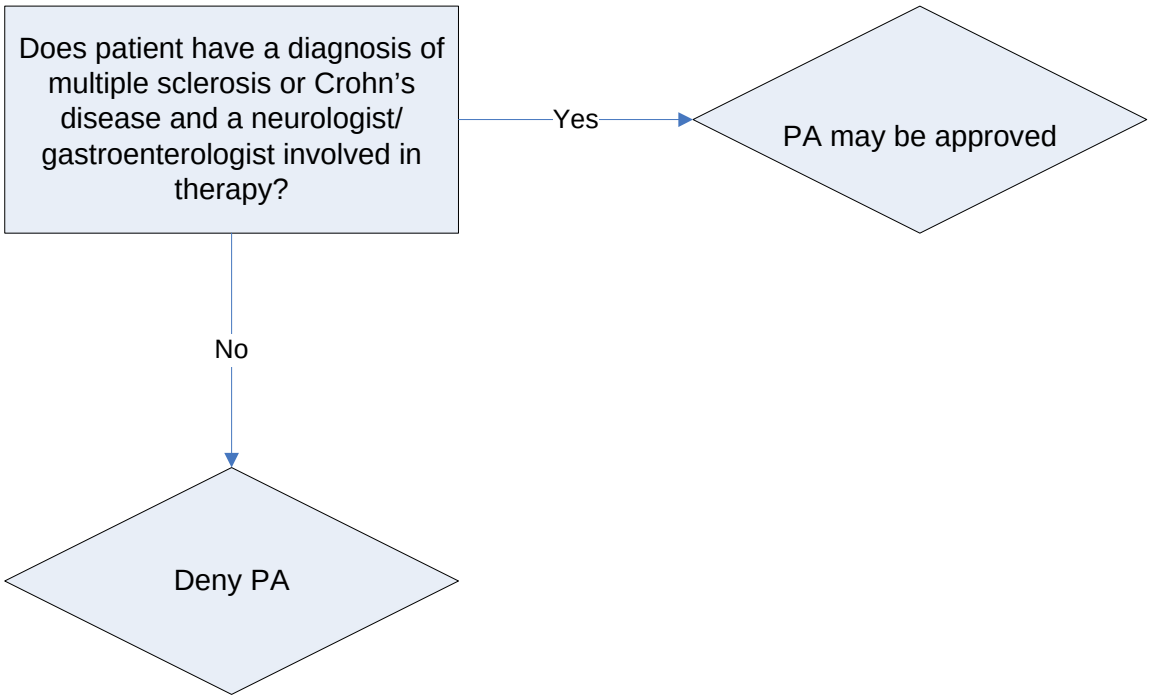
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Tysabri Prior Authorization Algorithm



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:

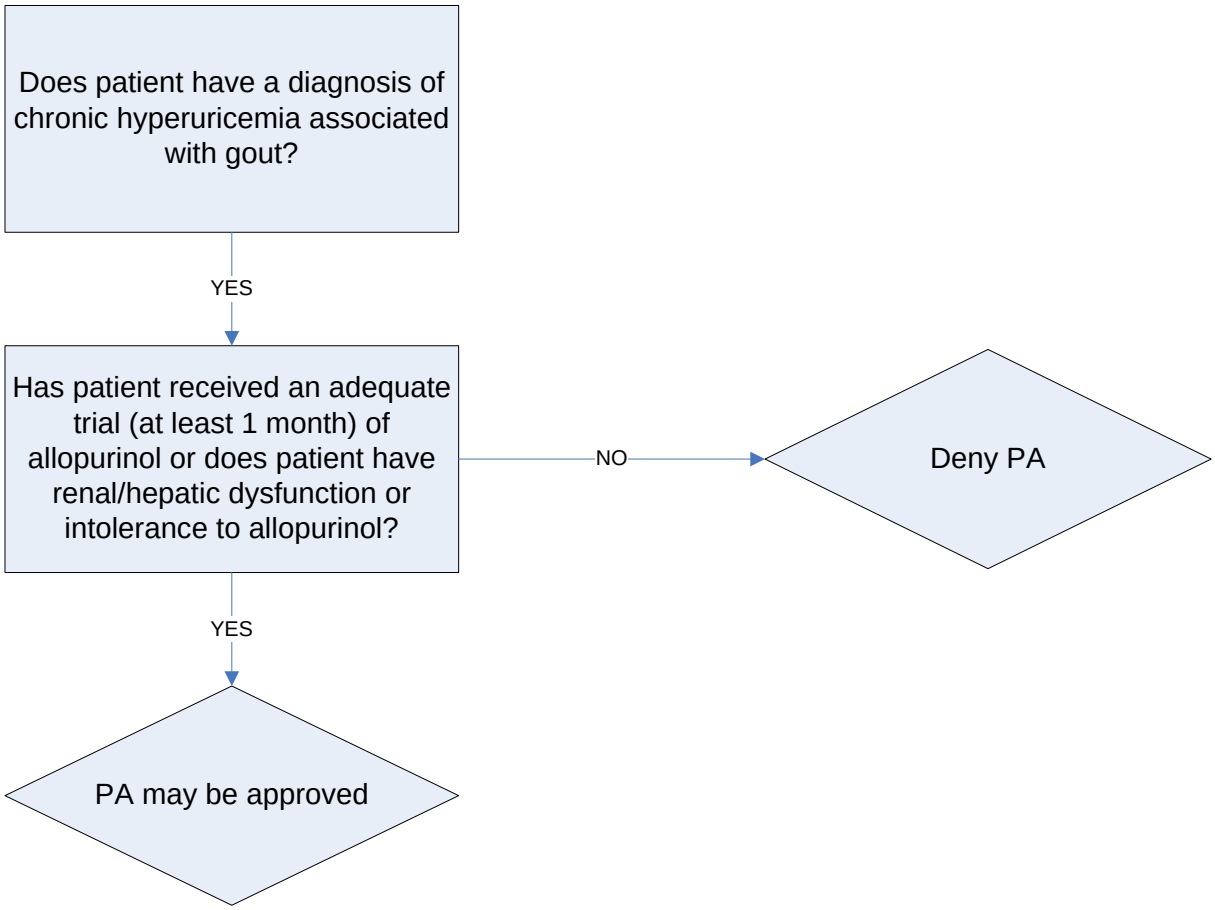
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Uloric Prior Authorization Algorithm



Allopurinol does not require a prior authorization

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

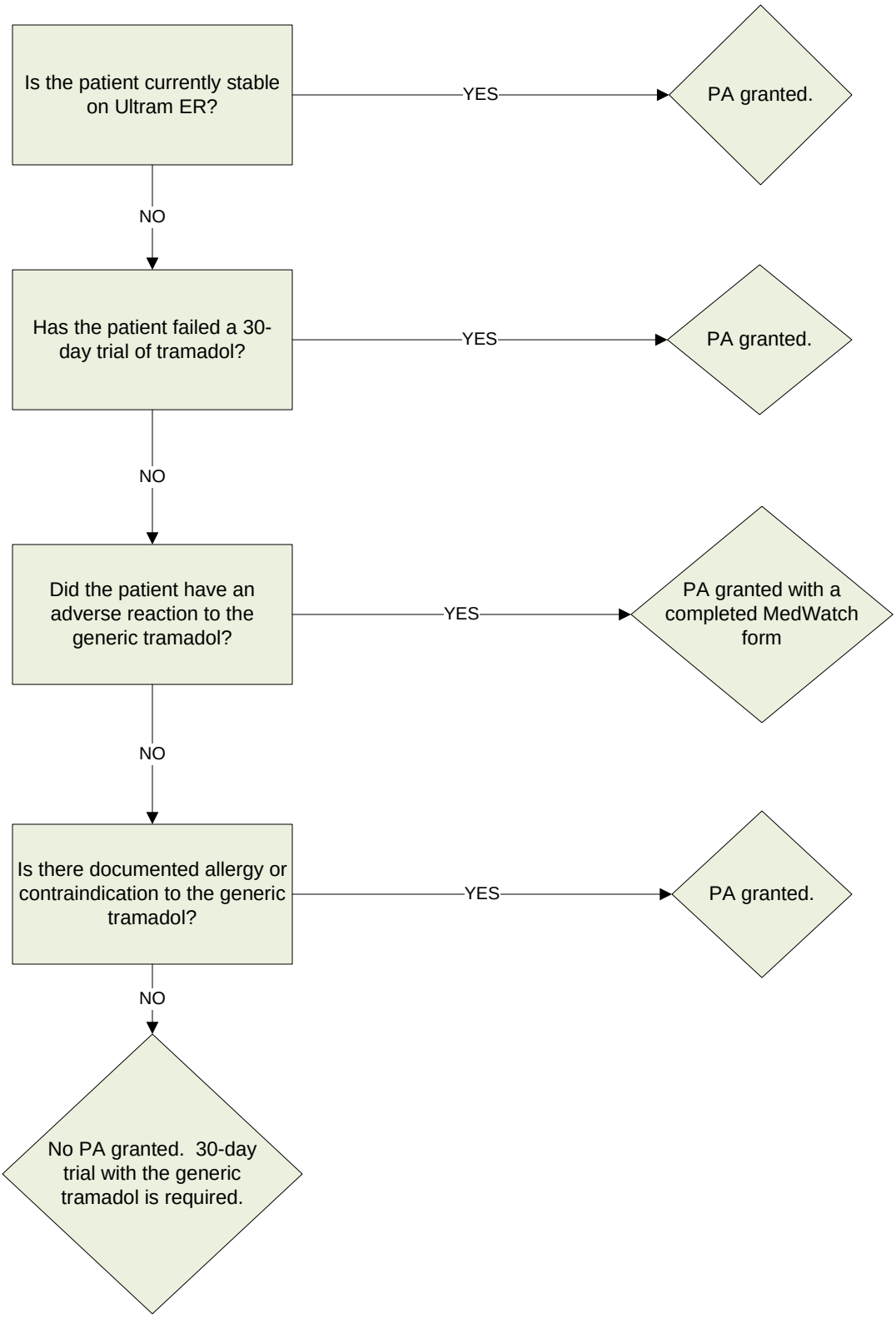
PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services

Ultram ER and Ryzolt
Criteria Algorithm



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:

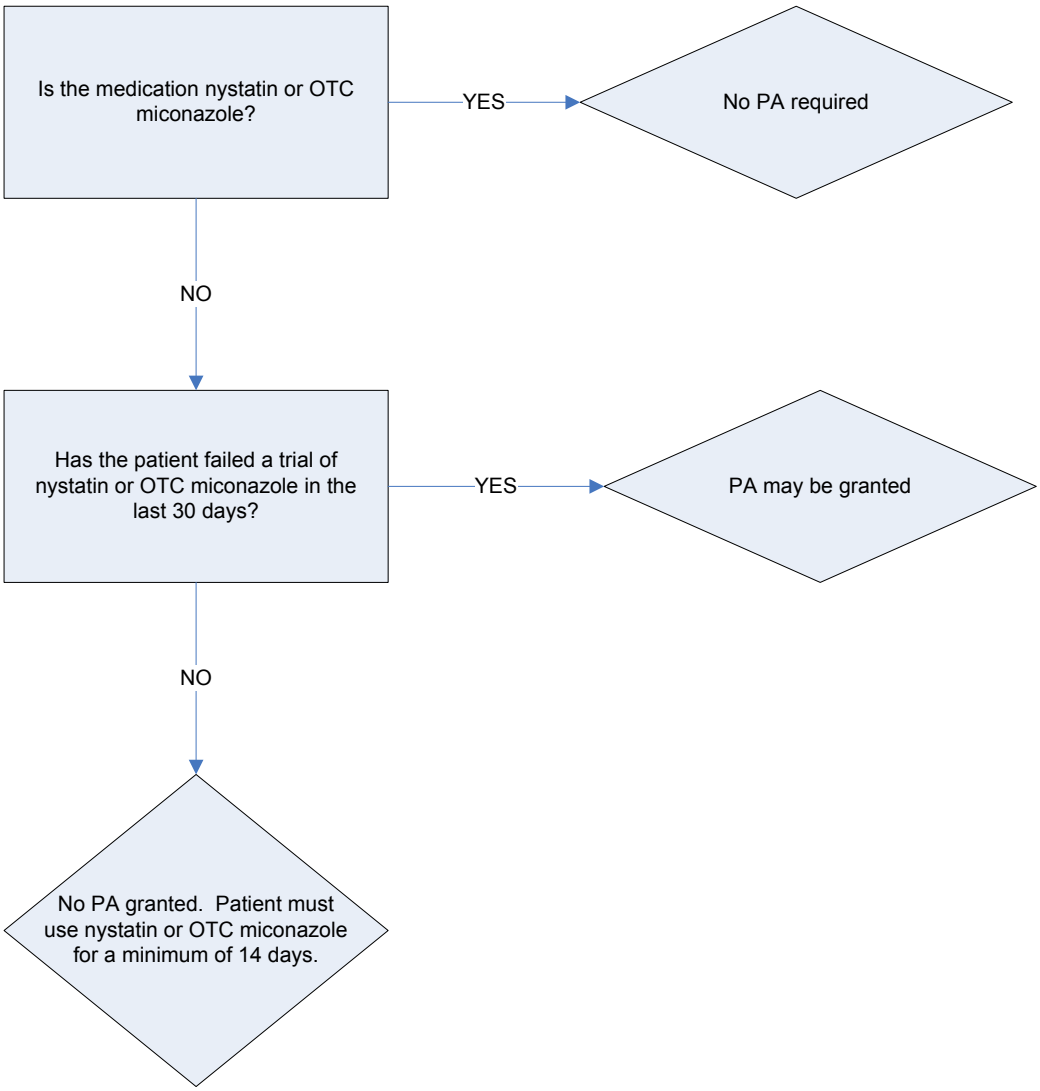
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Vusion Prior Authorization Criteria



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

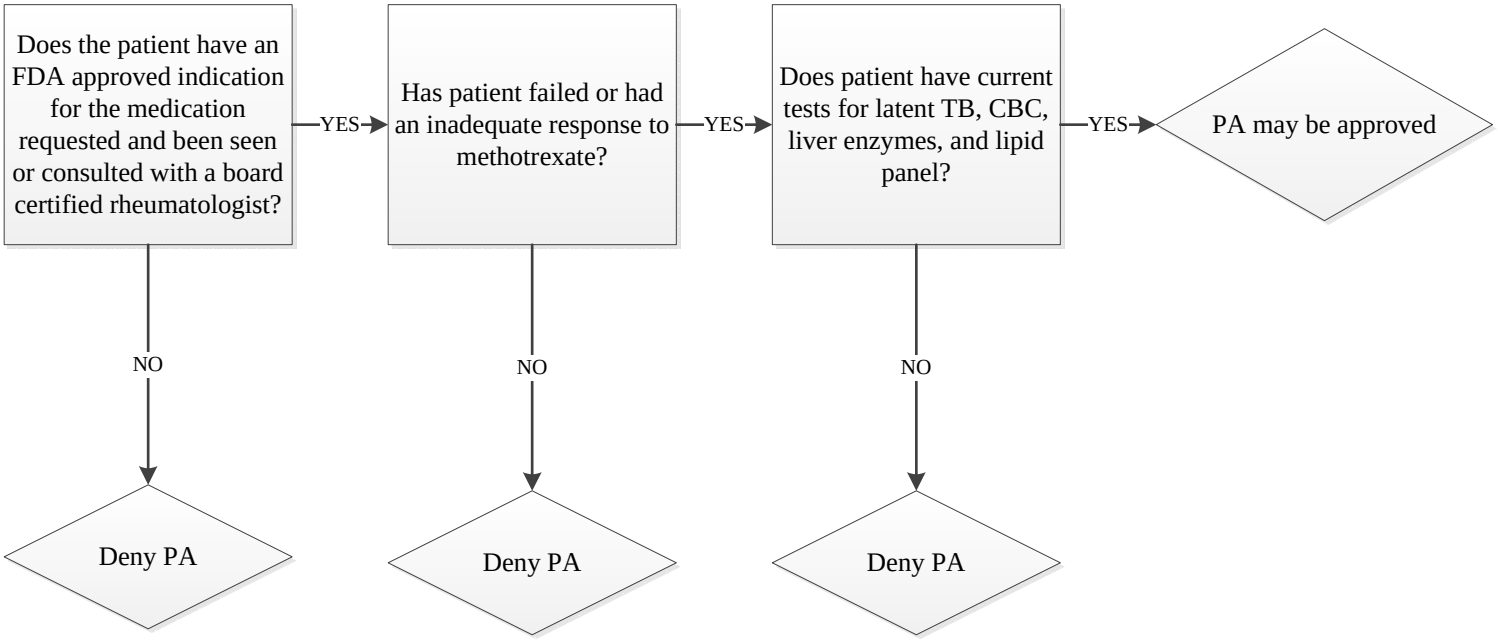
SD Medicaid requires that patients receiving a new prescription for Xeljanz must meet the following criteria:

- 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)	

South Dakota Department of Social Services
Xeljanz Authorization Algorithm



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:	

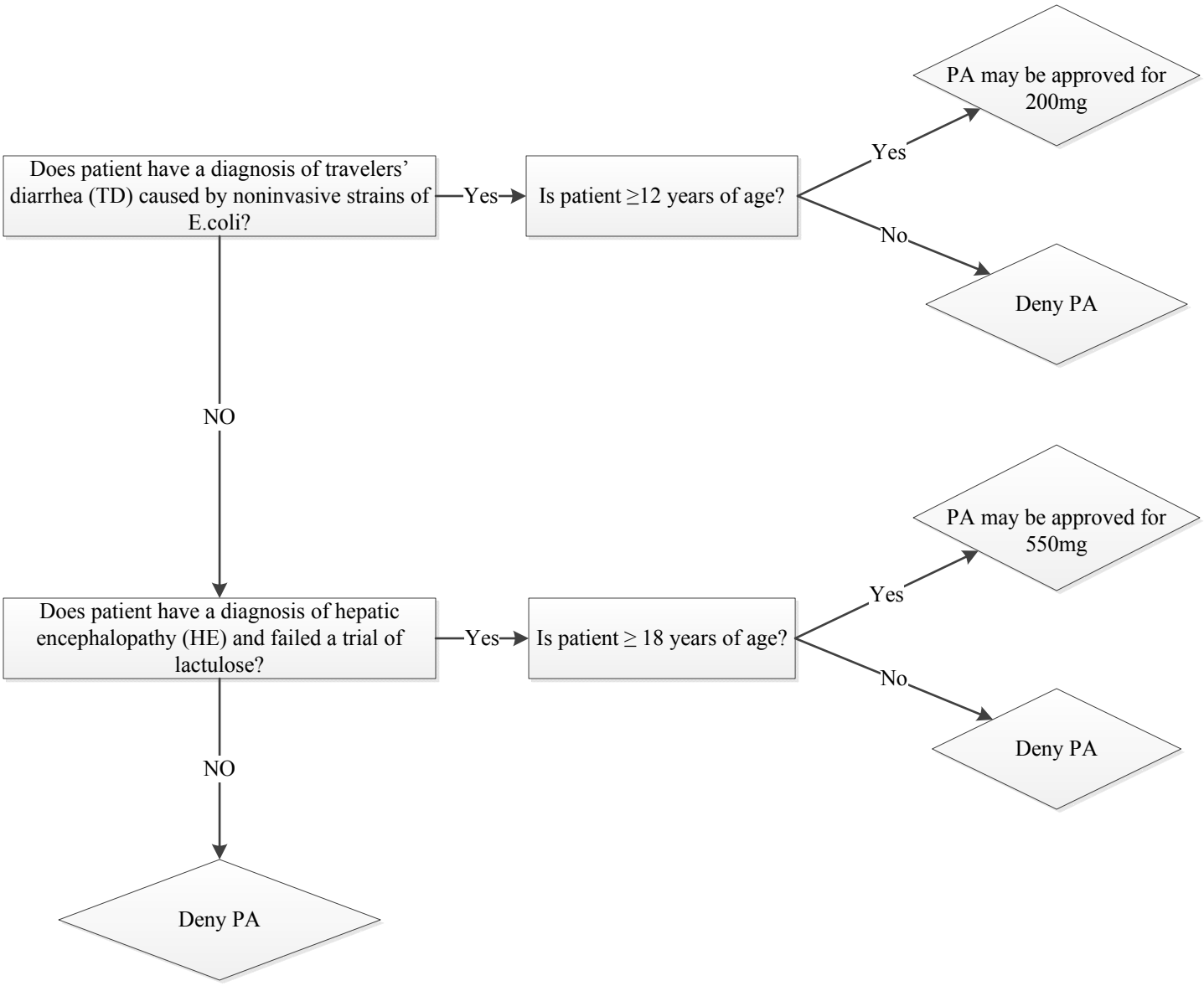
Part IV: PHARMACY INFORMATION

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)

South Dakota Department of Social Services
Xifaxan Authorization Algorithm



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

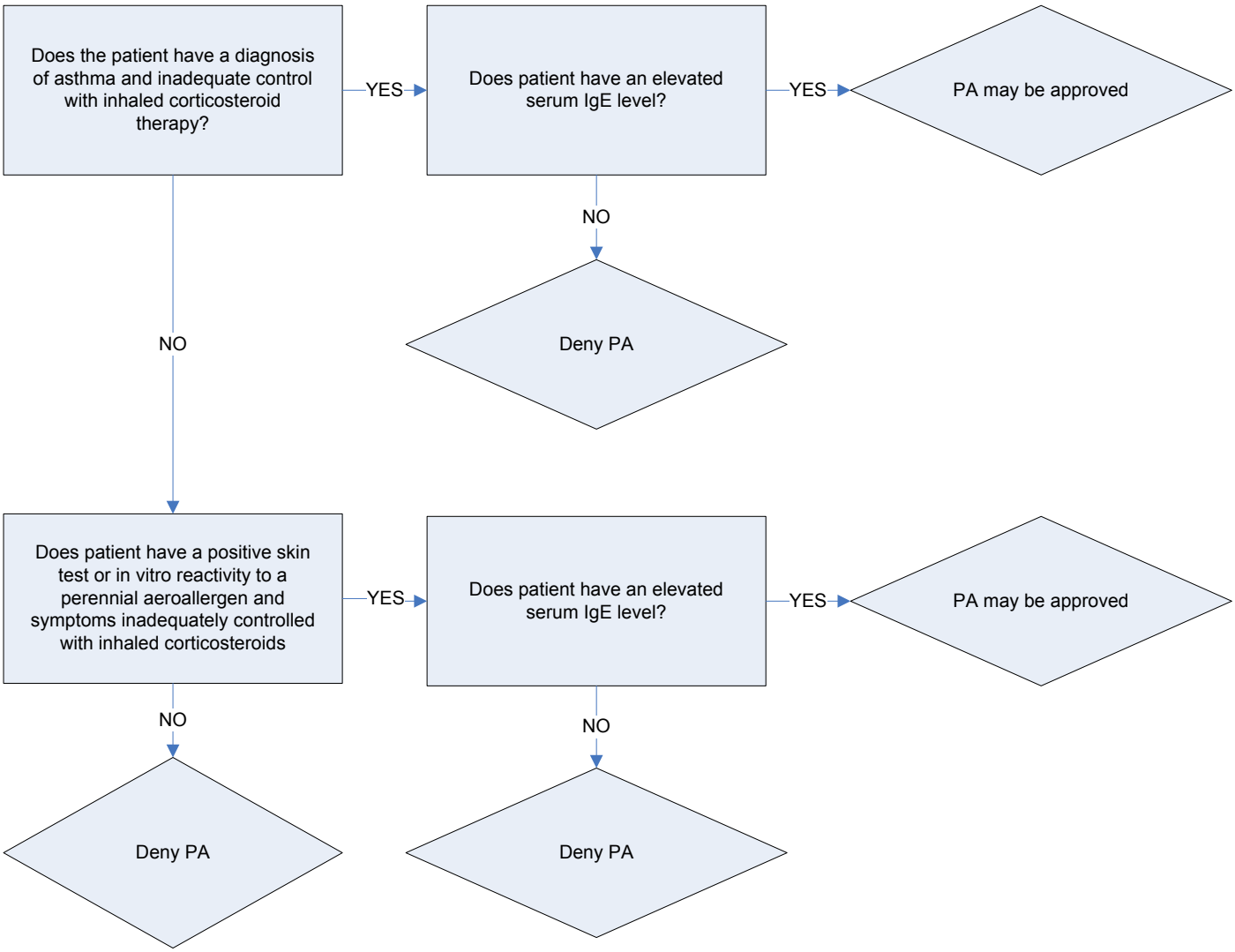
PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services

Xolair Prior Authorization Criteria



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:

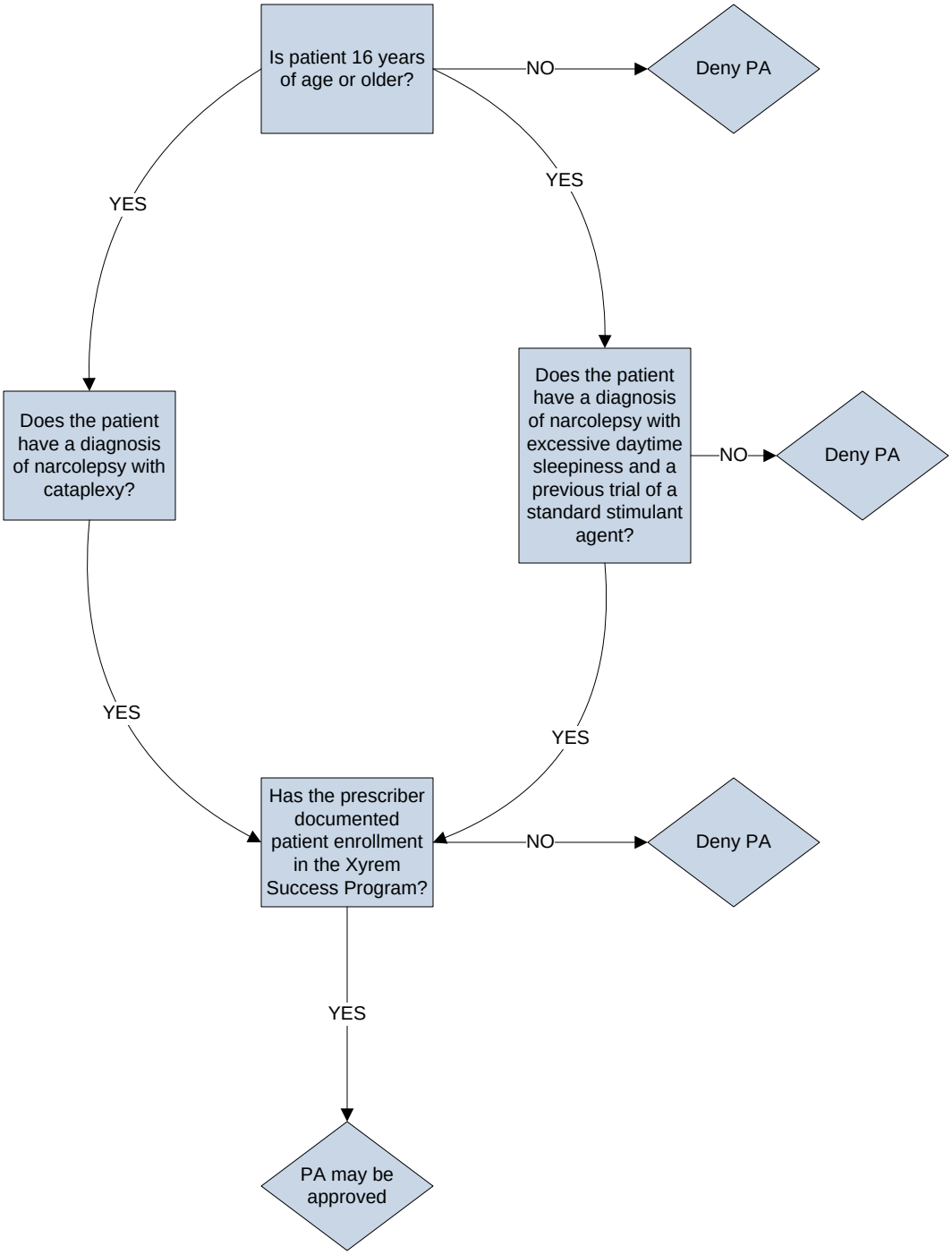
Part IV: PHARMACY INFORMATION

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)	

South Dakota Department of Social Services
Xyrem Prior Authorization Criteria



South Dakota Department of Social Services
Sovaldi Review

I. Indication

Sovaldi (sofosbuvir) is a hepatitis C virus (HCV) nucleotide analog NS5B polymerase inhibitor indicated for the treatment of chronic hepatitis C (CHC) infection as a component of a combination antiviral treatment regimen. Sovaldi efficacy has been established in subjects with HCV genotype 1, 2, 3, or 4 infection, including those with hepatocellular carcinoma meeting Milan criteria (awaiting liver transplantation) and those with HCV/HIV-1 co-infection.

II. Dosage and Administration

One 400 mg tablet taken once daily with or without food.

Should be used in combination with ribavirin or in combination with pegylated interferon and ribavirin for the treatment of CHC.

Recommended combination therapy:

HCV Mono-infected and HCV/HIV-1 Co-infected	Treatment	Duration
Genotype 1 or 4	Sovaldi + peg-interferon alfa + ribavirin	12 weeks
Genotype 2	Sovaldi + ribavirin	12 weeks
Genotype 3	Sovaldi + ribavirin	24 weeks

Sovaldi in combination with ribavirin for 24 weeks can be considered for CHC patients with genotype 1 infection who are interferon ineligible.

Should be used in combination with ribavirin for treatment of CHC in patients with hepatocellular carcinoma awaiting liver transplantation for up to 48 weeks or until liver transplantation, whichever occurs first.

A dose recommendation cannot be made for patients with severe renal impairment or end state renal disease.

III. Dosage Forms and Strengths

Sovaldi is available as a yellow colored, capsule-shaped, film-coated tablet containing 400mg sofosbuvir.

IV. Contraindications

When Sovaldi is used in combination with ribavirin or peginterferon alfa/ribavirin, the contraindications applicable to those agents are applicable to combination therapies.

Sovaldi combination treatment with ribavirin or peginterferon alfa/ribavirin is contraindicated in women who are pregnant or may become pregnant and men whose female partners are pregnant, because of the risks for birth defects and fetal death associated with ribavirin.

V. Warnings and Precautions

When Sovaldi is used in combination with ribavirin or peginterferon alfa/ribavirin, women of childbearing potential and their male partners must use two forms of effective contraception during treatment and for at least 6 months after treatment.

Drugs that are potent P-gp inducers in the intestine (e.g., rifampin, St. John's wort) may significantly decrease sofosbuvir plasma concentrations and may lead to a reduced therapeutic effect of Sovaldi.

VI. Adverse Reactions

The most common adverse events (≥ 20%) for Sovaldi + ribavirin combination therapy were fatigue and headache. The most common adverse events (≥ 20%) for Sovaldi + peginterferon alfa + ribavirin combination therapy were fatigue, headache, nausea, insomnia, and anemia.

VII. Drug Interactions

Anticonvulsants: Coadministration of Sovaldi with carbamazepine, phenytoin, phenobarbital, or oxcarbazepine is expected to decrease the concentration of sofosbuvir, leading to reduced therapeutic effect of Sovaldi. Coadministration is not recommended.

Antimycobacterials: Coadministration of Sovaldi with rifabutin or rifapentine is expected to decrease the concentration of sofosbuvir, leading to reduced therapeutic effect. Sovaldi should not be used with rifampin, a potent intestinal P-gp inducer.

Herbal Supplements: Sovaldi should not be used with St. John's wort, a potent intestinal P-gp inducer.

HIV Protease Inhibitors: Coadministration of Sovaldi with tipranavir/ritonavir is expected to decrease the concentration of sofosbuvir, leading to reduced therapeutic effect of Sovaldi. Coadministration is not recommended.

VIII. Use in Specific Populations

Pregnancy Category X

IX. Cost

~$80,000 12 weeks

References:

1. Sovaldi® [package insert]. Foster City, CA: Gilead Sciences, Inc; December 2013.

South Dakota Department of Social Services
Olysio Review

I. Indication

Olysio (simeprevir) is a hepatitis C virus (HCV) NS3/4A protease inhibitor indicated for the treatment of chronic hepatitis C (CHC) infection as a component of a combination antiviral treatment regimen.

- Olysio efficacy has been established in combination with peginterferon alfa and ribavirin in HCV genotype 1 infected subjects with compensated liver disease (including cirrhosis).
- Olysio must not be used as monotherapy.
- Screening patients with HCV genotype 1a infection for the presence of virus with the NS3 Q80K polymorphism at baseline is strongly recommended. Alternative therapy should be considered for patients infected with HCV genotype 1a containing the Q80K polymorphism.

II. Dosage and Administration

The recommended dose of Olysio is one 150 mg capsule take once daily with food. Olysio should be used in combination with peginterferon alfa and ribavirin.

The recommended treatment duration of Olysio with peginterferon alfa and ribavirin is 12 weeks, followed by either 12 or 36 additional weeks of peginterferon alfa and ribavirin depending on prior response status.

A dosage recommendation cannot be made for patients of East Asian ancestry or patients with moderate to severe hepatic impairment.

III. Dosage Forms and Strengths

Capsule: 150 mg

IV. Contraindications

All contraindications to peginterferon alfa and ribavirin also apply to Olysio combination treatment.

Because ribavirin may cause birth defects and fetal death, Olysio in combination with peginterferon alfa and ribavirin is contraindicated in pregnant women and men whose female partners are pregnant.

V. Warnings and Precautions

Embryofetal Toxicity (Use with ribavirin and peginterferon alfa)

Photosensitivity

Rash

VI. Adverse Reactions

The most common adverse events (greater than 20% of subjects) in subjects receiving the combination of Olysio with peginterferon alfa and ribavirin and occurring with at least 3% higher frequency compared to subjects receiving placebo in combination with peginterferon alfa and ribavirin during the first 12 weeks of treatment were: rash, pruritus, and nausea.

VII. Drug Interactions

Coadministration of Olysio with drugs that are moderate or strong inducers or inhibitors of CYP3A may significantly affect the plasma concentrations of simeprevir. The potential for drug-drug interactions must be considered prior to and during treatment.

VIII. Use in Specific Populations

Pregnancy Category X

IX. Cost

~$66,000 12 weeks

References:

1. Olysio® [package insert]. Titusville, NJ: Janssen Therapeutics; November 2013.

South Dakota Department of Social Services
Luzu Review

I. Indication

Luzu (luliconazole) is an azole antifungal topical cream indicated for the treatment of interdigital tinea pedis, tinea cruris, and tinea corporis caused by the organisms *Trichophyton rubrum* and *Epidermophyton floccosum,* in patients 18 years of age and older.

II. Dosage and Administration

When treating interdigital tinea pedis, a thin layer of Luzu cream should be applied to the affected area and approximately one inch of the immediate surrounding area once daily for two weeks.

When treating tinea cruris or tinea corporis, Luzu cream should be applied to the affected area and approximately one inch of the immediate surrounding area once daily for one week.

III. Dosage Forms and Strengths

Each gram of Luzu cream 1% contains 10mg of luliconazole in a white cream base.

IV. Contraindications

None

V. Adverse Reactions

The most common adverse reactions observed in clinical trials were application site reactions, which occurred in less than 1% of subjects. Most adverse reactions were mild in severity. Contact dermatitis and cellulitis have been identified during post-marketing use.

VI. Drug Interactions

The potential of luliconazole to inhibit cytochrome P-450 (CYP) enzymes 1A2, 2C9, 2C19, 2D6, and 3A4 was evaluated in vitro. Based on in vitro assessment, luliconazole at therapeutic doses, particularly when applied to patients with moderate to severe tinea cruris, may inhibit the activity of CYP2C19 and CYP3A4. However, no in vivo drug interaction trials have been conducted to evaluate the effect of luliconazole on other drugs that are substrates of CYP2C19 and CYP3A4.

Luliconazole is not expected to inhibit CYPs 1A2, 2C9 and 2D6 based on in vitro assessment. The induction potential of luliconazole on CYP enzymes has not been evaluated.

VII. Use in Specific Populations

Pregnancy Category C.

The safety and effectiveness of Luzu cream in pediatric patients have not been established.

VIII. Cost

$379.80 – 60gm

References:

1. Luzu® [package insert]. Bridgewater, NJ: Valeant Pharmaceuticals; November 2013.

South Dakota Department of Social Services
Hetlioz Review

I. Indication

Hetlioz (tasimelteon) is a melatonin receptor agonist indicated for the treatment of Non-24-Hour Sleep-Wake Disorder (Non-24).

II. Dosage and Administration

The recommended dosage of Hetlioz is 20mg per day taken before bedtime, at the same time every night. Because of individual difference in circadian rhythms, drug effect may not occur for weeks or months.

III. Dosage Forms and Strengths

Capsule: 20mg

IV. Contraindications

None

V. Warnings and Precautions

After taking Hetlioz, patients should limit their activity to preparing for going to bed. Hetlioz can potentially impair the performance of activities requiring complete mental alertness.

VI. Adverse Reactions

The most common adverse reactions observed in clinical trials were headache, alanine aminotransferase increased, nightmare/abnormal dreams, upper respiratory tract infection, and urinary tract infection.

VII. Drug Interactions

Avoid use of Hetlioz in combination with fluvoxamine or other strong CYP1A2 inhibitors because of a potentially large increase in tasimelteon exposure and greater risk of adverse reactions.

Avoid use of Hetlioz in combination with rifampin or other CYP3A4 inducers because of a potentially large decrease in tasimelteon exposure with reduced efficacy.

VIII. Use in Specific Populations

Pregnancy Category C.

The safety and effectiveness of Hetlioz in pediatric patients have not been established.

The risk of adverse reactions may be greater in elderly (>65 years) patients than younger patients because exposure to tasimelteon is increased by approximately 2-fold compared with younger patients.

References:

1. Hetlioz® [package insert]. Washington, D.C.: Vanda Pharmaceuticals; January 2014.