South Dakota Department of Social Services

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Gralise® & Horizant® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Moderate to severe primary restless leg syndrome (RLS) [**Horizant** only]
- ❑ Neuropathic pain associated with postherpetic neuralgia (PHN)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Moderate to severe primary RLS:

Has the patient had a trial and failure (to a minimum of a 90 day trial), contraindication, or intolerance to ropinirole or pramipexole in the past 180 days? ❑ **Yes** ❑ **No**

Neuropathic pain associated with PHN:

Has the patient had a trial and failure (to a minimum of a 90 day trial), contraindication, or intolerance to an immediate-release gabapentin in the past 180 days? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.