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

Hydrocodone-acetaminophen (APAP) Products
Prior Authorization Request Form (Page 1 of 2)

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)

Medication history:

Has the patient had a history of a 60 day trial (in the past 90 days) with one of the following generics listed below? ❑ **Yes** ❑ **No**

- Hydrocodone-APAP 5-325
- Hydrocodone-APAP 7.5-325
- Hydrocodone-APAP 10-325

Clinical information:

Does the patient have a diagnosis of cancer in the past 365 days? ❑ **Yes** ❑ **No**

Does the patient have a diagnosis of a terminal illness? ❑ **Yes** ❑ **No**

Does the patient have an illness associated with significant pain (e.g., sickle cell anemia, etc)? ❑ **Yes** ❑ **No**
If **yes**, please list the diagnosis: _____

Does the patient have an injury associated with significant pain? ❑ **Yes** ❑ **No**
If **yes**, please list the diagnosis: _____

Have efforts been made to taper the patient to the lowest effective dose? ❑ **Yes** ❑ **No**
If **yes**, please provide documentation: _____

_____

_____

Reauthorization:

If this is a reauthorization request, answer the following:

Is the prescriber maintaining the most conservative, effective treatment? ❑ **Yes** ❑ **No**
If **yes**, please provide documentation: _____

_____

_____

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

_____

_____

_____

_____

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.