South Dakota Department of Social Services

Medicaid P&T Committee Meeting

April 1, 2016

Prepared by Health Information Designs, LLC

DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES
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SOUTH DAKOTA
MEDICAID P&T COMMITTEE MEETING
AGENDA

Friday, April 1, 2016
1:00 – 3:00 PM

DDN Locations:
Sioux Falls
University Center
Room FADM253
4801 North Career Avenue

Pierre
Capitol Building
DDN Room A
500 E Capitol

Rapid City
Black Hills State University
Room UC125
4300 Cheyenne Boulevard

Call to order

Approval of minutes of previous meeting

Prior authorization update

Review of top 15 therapeutic categories/top 50 drugs

Old business
- **Review of hydrocodone/APAP utilization**
- **Review of PCSK9 PA form**
- **Review of Lyrica PA form**
- **Review of Otrexup PA form**
- **Review of Durlaza PA form**
- **Annual PA forms review**

New business
- **Narcan Nasal Spray**
- **Tivorbex**
- **Nucala**
- **Varubi**
- **Zurampic**

Oral presentations and comments by manufacturers' representatives

Next meeting date/adjournment

Minutes of the December 4, 2015
Pharmacy & Therapeutics (P&T) Committee Meeting
South Dakota Department of Social Services, Division of Medical Services

Members present

Bill Ladwig; Michelle Baack; Richard Holm; Dana Darger; James Engelbrecht; Lenny Petrik; Kelley Oehlke Tim Soundy

DSS staff present

Mike Jockheck, RPh

Administrative business

The P&T meeting was called to order by D. Darger at 1:00 p.m. The minutes of the September meeting were presented. B. Ladwig made a motion to approve. M. Baack seconded the motion. The motion was approved unanimously.

Prior authorization update and statistics

The committee reviewed the prior authorization (PA) activity for October 2015. There were a total of 3,085 PAs processed in the month of August, with 98.66% of those requests responded to in less than eight hours. There were 2,460 requests (79%) received electronically and 667 requests (21%) received by fax.

Analysis of the top 15 therapeutic classes

The committee reviewed the top 15 therapeutic classes by total cost of claims from 07/1/2015 – 09/30/2015. The top five classes were antipsychotics, respiratory and CNS stimulants, amphetamines, insulins, and anticonvulsants, misc. The top 15 therapeutic classes make up 37.60% of total claims. The committee also reviewed the top 50 drugs based on total claims cost and number of claims. The top 50 drugs by claims cost make up 17.77% of total claims. The committee asked for a review of patients taking hydrocodone. The committee also requested an update on epatitis C.

Review of drug spend

The committee reviewed a table showing SD Medicaid drug spend from 2012 – October 2015. The average cost per script rose from $64.45 in 2012 to $81.35 in 2015. The average recipient script cost rose from $172.76 in 2012 to $223.35 in 2015.

Patent expirations

The committee reviewed a list of medications with an upcoming anticipated availability of a first-time generic.

Orkambi second review

The committee reviewed the prior authorization form provided for Orkambi. There was no public comment. The committee requested that a bullet point be added to the form for ‘specialist involved in therapy.’ M. Baack made a motion to approve the form as amended. B. Ladwig seconded the motion. The motion was approved unanimously.

Chronic constipation medications second review
The committee reviewed the prior authorization form provided for chronic constipation medications. There was no public comment. J. Engelbrecht made a motion to approve the form. R. Holm seconded the motion. The motion was approved unanimously.

Viberzi second review
The committee reviewed the prior authorization form provided for Viberzi. There was no public comment. M. Baack made a motion to approve the form. K. Oehlke seconded the motion. The motion was approved unanimously.

PCSK9 inhibitors second review
The committee reviewed the prior authorization form provided for PCSK9 inhibitors. M. Lewis, representing Amgen spoke regarding Repatha. The committee requested that 'and' be added to the diagnosis wording for it to read 'diagnosis of HeFH, HoFH, and clinical atherosclerotic cardiovascular disease.' The committee requested examples of how other states are managing this class be brought back to the next meeting report on any prior authorizations that are requested in January, February, and March.

Antipsychotic data
C. Rieth gave an overview of antipsychotic prior authorizations from July 2015. Charts were provided showing total claims cost, total patients, and total RXs.

PPI data
C. Rieth gave an overview of proton pump inhibitor data from October 29, 2014 through October 28, 2015. There were 5,324 recipients receiving PPI therapy during this time. The committee requested that the prior authorization form for PPIs be reviewed at the next meeting.

Enbrel/Humira data
C. Rieth gave an overview of Enbrel and Humira utilization from October 29, 2014 through October 28, 2015. The committee requested that the state provide net pricing of these agents at the next meeting.

Lyrica data
C. Rieth gave an overview of Lyrica utilization from October 29, 2014 through October 28, 2015. J. Engelbrecht made a motion to place Lyrica on prior authorization. L. Petrik seconded the motion. There was no public comment. A prior authorization form will be brought back to the next meeting for committee review.

Hydrocodone utilization
C. Rieth gave an overview of hydrocodone/APAP utilization from January 2014 through June 2015. Total patients, total claims cost, and total number of RXs were provided. The committee asked that additional information be provided at the next meeting including: top 10% of utilizers, top prescribers/providers, and quantities dispensed.

Otrexup review
The committee reviewed Otrexup clinical information. There was no public comment. B. Ladwig made a motion to place Otrexup on prior authorization. R. Holm seconded. The motion passed unanimously. A form will be brought to the next meeting for review.

Durlaza review
The committee reviewed Durlaza clinical information. There was no public comment. B. Ladwig made a motion to place Durlaza on prior authorization. R. Holm seconded the motion. The motion passed unanimously. A form will be brought to the next meeting for review.

The next meeting is scheduled for April 1, 2016. M. Baack made a motion to adjourn the P&T Committee meeting. R. Holm seconded the motion. The motion passed unanimously and the meeting was adjourned.

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South Dakota Medicaid
Monthly Prior Authorization Report
January 1, 2016 – January 31, 2016

Time Ratio

Total PAs	Response Under 8 Hours	Response Over 8 Hours	% Under 8 Hours	% Over 8 Hours
2,829	2,829	0	100.00%	0.00%

By Form Type

Form Type	Description	Approve	Deny
ADP	Antidepressant	150	231
AFX	Amrix and Fexmid	2	0
ALT	Altabax	0	1
AMB	Ambien CR	5	7
ANT	Antihistamines	2	19
APS	Antipsychotic	285	317
ARB	ARBS	2	1
COA	Oral Anticoagulants	6	21
DAW	Dispense As Written	11	1
EME	Antiemetics	0	1
GRH	Growth Hormone	2	0
GSM	Genitourinary SMR	5	146
HEP	Hepatitis Meds	1	2
HLM	Head Lice Medication	9	1
LID	Lidoderm	0	65
MAX	Max Units Override	78	991
MSA	Multiple Sclerosis Agents	0	1
NAR	Name Brand Narcotics	5	0
NUC	Opioids	3	5
ONF	Onfi	9	2
OPH	Ophthalmic Antihistamines	1	4
PPI	Proton Pump Inhibitors	40	87
SAN	Sancuso	0	1
SMR	Skeletal Muscle Relaxants	0	3
STE	Nasal Steroids	4	41
STI	Stimulants	4	10
SUB	Suboxone/Subutex	5	13
TIM	Targeted Immune Modulators	8	9
TOP	Topical Acne Agents	23	98
TRP	Triptans	10	50
ULT	Ultram ER	1	9
XIF	Xifaxan	1	16
XOI	Xanthine Oxidase Inhibitor	0	3
XOL	Xolair	1	0
Totals		673	2156

health information designs

South Dakota Medicaid
Monthly Prior Authorization Report
January 1, 2016 – January 31, 2016

By Request Type

01/01/16 - 01/31/16	Requests	Electronic Requests		Faxed Requests	
	#		%	#	%
Prior Authorizations:					
Antidepressant	381	285	75%	96	25%
Amrix and Fexmid	2	2	100%	0	0%
Altabax	1	1	100%	0	0%
Ambien CR	12	8	67%	4	33%
Antihistamines	21	17	81%	4	19%
Antipsychotic	602	397	66%	205	34%
ARBS	3	1	33%	2	67%
Oral Anticoagulants	27	22	81%	5	19%
Dispense As Written	12	0	0%	12	100%
Antiemetics	1	1	100%	0	0%
Growth Hormone	2	0	0%	2	100%
Genitourinary SMR	151	143	95%	8	5%
Hepatitis Meds	3	0	0%	3	100%
Head Lice Medication	10	0	0%	10	100%
Lidoderm	65	54	83%	11	17%
Max Units Override	1069	1002	94%	67	6%
Multiple Sclerosis Agents	1	0	0%	1	100%
Name Brand Narcotics	5	0	0%	5	100%
Opioids	8	7	88%	1	13%
Onfi	11	0	0%	11	100%
Ophthalmic Antihistamines	5	4	80%	1	20%
Proton Pump Inhibitors	127	95	75%	32	25%
Sancuso	1	0	0%	1	100%
Skeletal Muscle Relaxants	3	3	100%	0	0%
Nasal Steroids	45	36	80%	9	20%
Stimulants	14	9	64%	5	36%
Suboxone/Subutex	18	12	67%	6	33%
Targeted Immune Modulators	17	8	47%	9	53%
Topical Acne Agents	121	83	69%	38	31%
Triptans	60	48	80%	12	20%
Ultram ER	10	10	100%	0	0%
Xifaxan	17	12	71%	5	29%
Xanthine Oxidase Inhibitor	3	2	67%	1	33%
Xolair	1	0	0%	1	100%
Prior Authorization Totals	2829	2262	80%	567	20%

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South Dakota Medicaid
Monthly Prior Authorization Report
January 1, 2016 – January 31, 2016

Electronic PAs (unique)

01/01/16 - 01/31/16	# Unique Approved	# Unique Denied	# Unique Incomplete	Unique Total	Approval %	Total Transactions
Prior Authorizations:						
Antidepressant	95	176	0	271	35.10%	285
Amrix and Fexmid	2	0	0	2	100.00%	2
Altabax	0	1	0	1	0.00%	1
Ambien CR	3	3	0	6	50.00%	8
Antihistamines	1	16	0	17	5.90%	17
Antipsychotic	122	255	0	377	32.40%	397
ARBS	0	1	0	1	0.00%	1
Oral Anticoagulants	2	15	0	17	11.80%	22
Antiemetics	0	1	0	1	0.00%	1
Genitourinary SMR	1	21	0	22	4.50%	143
Lidoderm	0	53	0	53	0.00%	54
Max Units Override	31	894	0	925	3.40%	1002
Opioids	3	4	0	7	42.90%	7
Ophthalmic Antihistamines	1	3	0	4	25.00%	4
Proton Pump Inhibitors	20	71	0	91	22.00%	95
Skeletal Muscle Relaxants	0	3	0	3	0.00%	3
Nasal Steroids	2	32	0	34	5.90%	36
Stimulants	0	8	0	8	0.00%	9
Suboxone/Subutex	0	10	0	10	0.00%	12
Targeted Immune Modulators	0	8	0	8	0.00%	8
Topical Acne Agents	4	78	0	82	4.90%	83
Triptans	4	41	0	45	8.90%	48
Ultram ER	1	7	0	8	12.50%	10
Xifaxan	0	12	0	12	0.00%	12
Xanthine Oxidase Inhibitor	0	2	0	2	0.00%	2
TOTALS	292	1715	0	2007	14.50%	2262

SOUTH DAKOTA MEDICAID
Cost Management Analysis

TOP 50 DRUGS BASED ON NUMBER OF CLAIMS FROM 10/01/2015 - 12/31/2015

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
AMOXICILLIN	PENICILLINS	7,413	$ 63,766.35	$ 8.60	3.44%
HYDROCODONE-ACETAMINOPHEN	OPIATE AGONISTS	5,942	$ 141,021.99	$ 23.73	2.76%
AZITHROMYCIN	MACROLIDES	4,534	$ 84,915.31	$ 18.73	2.11%
OMEPRAZOLE	PROTON-PUMP INHIBITORS	4,230	$ 46,549.84	$ 11.00	1.96%
METHYLPHENIDATE ER	RESPIRATORY AND CNS STIMULANTS	3,961	$ 758,400.08	$ 191.47	1.84%
MONTELUKAST SODIUM	LEUKOTRIENE MODIFIERS	3,671	$ 76,014.14	$ 20.71	1.70%
FLUOXETINE HCL	ANTIDEPRESSANTS	3,560	$ 39,178.32	$ 11.01	1.65%
CETIRIZINE HCL	SECOND GENERATION ANTIHISTAMINES	3,450	$ 25,262.78	$ 7.32	1.60%
VYVANSE	AMPHETAMINES	3,282	$ 702,582.30	$ 214.07	1.52%
SERTRALINE HCL	ANTIDEPRESSANTS	3,270	$ 24,477.17	$ 7.49	1.52%
LEVOTHYROXINE SODIUM	THYROID AGENTS	3,159	$ 49,035.48	$ 15.52	1.47%
TRAMADOL HCL	OPIATE AGONISTS	3,044	$ 24,971.32	$ 8.20	1.41%
TRAZODONE HCL	ANTIDEPRESSANTS	2,756	$ 17,315.12	$ 6.28	1.28%
ALBUTEROL SULFATE	BETA-ADRENERGIC AGONISTS	2,656	$ 50,991.68	$ 19.20	1.23%
LISINOPRIL	ANGIOTENSIN-CONVERTING ENZYME INHIBITORS	2,428	$ 13,228.69	$ 5.45	1.13%
GABAPENTIN	ANTICONVULSANTS, MISCELLANEOUS	2,376	$ 42,117.62	$ 17.73	1.10%
DEXTROAMPHETAMINE-AMPHET ER	AMPHETAMINES	2,212	$ 267,881.52	$ 121.10	1.03%
LORATADINE	SECOND GENERATION ANTIHISTAMINES	2,150	$ 12,728.05	$ 5.92	1.00%
VENTOLIN HFA	BETA-ADRENERGIC AGONISTS	2,143	$ 109,366.89	$ 51.03	1.00%
GUANFACINE HCL ER	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	2,086	$ 52,658.82	$ 25.24	0.97%
AMOXICILLIN-CLAVULANATE POTASS	PENICILLINS	1,968	$ 50,442.22	$ 25.63	0.91%
FLUTICASONE PROPIONATE	CORTICOSTEROIDS (EENT)	1,957	$ 26,054.35	$ 13.31	0.91%
CLONIDINE HCL	CENTRAL ALPHA-AGONISTS	1,918	$ 12,566.21	$ 6.55	0.89%
CLONAZEPAM	BENZODIAZEPINES (ANTICONVULSANTS)	1,861	$ 15,137.16	$ 8.13	0.86%
CEFDINIR	CEPHALOSPORINS	1,756	$ 85,717.56	$ 48.81	0.82%
CEPHALEXIN	CEPHALOSPORINS	1,731	$ 27,571.16	$ 15.93	0.80%
SULFAMETHOXAZOLE-TRIMETHOPRIM	SULFONAMIDES (SYSTEMIC)	1,726	$ 46,475.00	$ 26.93	0.80%
PREDNISONE	ADRENALS	1,684	$ 13,049.37	$ 7.75	0.78%
POLYETHYLENE GLYCOL 3350	CATHARTICS AND LAXATIVES	1,654	$ 41,787.35	$ 25.26	0.77%
PROAIR HFA	BETA-ADRENERGIC AGONISTS	1,653	$ 91,704.16	$ 55.48	0.77%
IBUPROFEN	NONSTEROIDAL ANTI-INFLAMMATORY AGENTS	1,620	$ 11,728.78	$ 7.24	0.75%
METFORMIN HCL	BIGUANIDES	1,614	$ 11,824.15	$ 7.33	0.75%
CITALOPRAM HBR	ANTIDEPRESSANTS	1,567	$ 9,314.27	$ 5.94	0.73%
VITAMIN D2	VITAMIN D	1,550	$ 9,446.40	$ 6.09	0.72%
LORAZEPAM	BENZODIAZEPINES (ANXIOLYTIC,SEDATIV/HYP)	1,475	$ 10,587.33	$ 7.18	0.69%
OXYCODONE-ACETAMINOPHEN	OPIATE AGONISTS	1,440	$ 43,953.51	$ 30.52	0.67%
RISPERIDONE	ANTIPSYCHOTIC AGENTS	1,414	$ 16,303.00	$ 11.53	0.66%
CYCLOBENZAPRINE HCL	CENTRALLY ACTING SKELETAL MUSCLE RELAXNT	1,403	$ 9,492.17	$ 6.77	0.65%
ARIPIPRAZOLE	ANTIPSYCHOTIC AGENTS	1,381	$ 646,500.86	$ 468.14	0.64%
LAMOTRIGINE	ANTICONVULSANTS, MISCELLANEOUS	1,379	$ 19,315.03	$ 14.01	0.64%
TRIAMCINOLONE ACETONIDE	ANTI-INFLAMMATORY AGENTS (SKIN & MUCOUS)	1,316	$ 18,192.68	$ 13.82	0.61%
ONDANSETRON ODT	5-HT3 RECEPTOR ANTAGONISTS	1,302	$ 16,927.01	$ 13.00	0.60%
QUETIAPINE FUMARATE	ANTIPSYCHOTIC AGENTS	1,273	$ 20,903.51	$ 16.42	0.59%
VENLAFAXINE HCL ER	ANTIDEPRESSANTS	1,155	$ 23,848.91	$ 20.65	0.54%
ESCITALOPRAM OXALATE	ANTIDEPRESSANTS	1,143	$ 10,809.14	$ 9.46	0.53%
TOPIRAMATE	ANTICONVULSANTS, MISCELLANEOUS	1,122	$ 13,149.21	$ 11.72	0.52%
LEVETIRACETAM	ANTICONVULSANTS, MISCELLANEOUS	1,114	$ 28,934.02	$ 25.97	0.52%
PREDNISOLONE SODIUM PHOSPHATE	ADRENALS	1,102	$ 10,910.67	$ 9.90	0.51%
DEXMETHYLPHENIDATE HCL ER	RESPIRATORY AND CNS STIMULANTS	1,095	$ 226,616.98	$ 206.96	0.51%
BUPROPION XL	ANTIDEPRESSANTS	1,082	$ 31,421.60	$ 29.04	0.50%
TOTAL TOP 50		112,778	$ 4,203,147.24	$ 37.27	52.38%

Total Rx Claims From 10/01/2015 - 12/31/2015	215,327

SOUTH DAKOTA MEDICAID
Cost Management Analysis

TOP 50 DRUGS BASED ON TOTAL CLAIMS COST FROM 10/01/2015 - 12/31/2015

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
METHYLPHENIDATE ER	RESPIRATORY AND CNS STIMULANTS	3,961	$ 758,400.08	$ 191.47	1.84%
VYVANSE	AMPHETAMINES	3,282	$ 702,582.30	$ 214.07	1.52%
ARIPIPRAZOLE	ANTIPSYCHOTIC AGENTS	1,381	$ 646,500.86	$ 468.14	0.64%
LATUDA	ANTIPSYCHOTIC AGENTS	421	$ 372,601.66	$ 885.04	0.20%
STRATTERA	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	995	$ 326,556.43	$ 328.20	0.46%
ADVATE	HEMOSTATICS	6	$ 325,900.53	$ 54,316.76	0.00%
LYRICA	ANTICONVULSANTS, MISCELLANEOUS	805	$ 311,131.69	$ 386.50	0.37%
HUMIRA PEN	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	69	$ 274,313.05	$ 3,975.55	0.03%
DEXTROAMPHETAMINE-AMPHET ER	AMPHETAMINES	2,212	$ 267,881.52	$ 121.10	1.03%
INVEGA SUSTENNA	ANTIPSYCHOTIC AGENTS	163	$ 254,123.33	$ 1,559.04	0.08%
LANTUS SOLOSTAR	INSULINS	604	$ 251,131.35	$ 415.78	0.28%
HARVONI	HCV ANTIVIRALS	7	$ 228,722.10	$ 32,674.59	0.00%
DEXMETHYLPHENIDATE HCL ER	RESPIRATORY AND CNS STIMULANTS	1,095	$ 226,616.98	$ 206.96	0.51%
ADVAIR DISKUS	CORTICOSTEROIDS (RESPIRATORY TRACT)	703	$ 224,255.06	$ 319.00	0.33%
NOVOLOG FLEXPEN	INSULINS	451	$ 215,699.81	$ 478.27	0.21%
SOVALDI	HCV ANTIVIRALS	6	$ 175,398.60	$ 29,233.10	0.00%
FLOVENT HFA	CORTICOSTEROIDS (RESPIRATORY TRACT)	895	$ 172,645.06	$ 192.90	0.42%
PREVACID	PROTON-PUMP INHIBITORS	407	$ 168,499.49	$ 414.00	0.19%
PULMOZYME	MUCOLYTIC AGENTS	58	$ 162,440.39	$ 2,800.70	0.03%
NOVOLOG	INSULINS	425	$ 161,691.98	$ 380.45	0.20%
ONFI	BENZODIAZEPINES (ANTICONVULSANTS)	154	$ 143,823.37	$ 933.92	0.07%
HYDROCODONE-ACETAMINOPHEN	OPIATE AGONISTS	5,942	$ 141,021.99	$ 23.73	2.76%
LEVEMIR FLEXTOUCH	INSULINS	306	$ 140,692.10	$ 459.78	0.14%
ENBREL	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	43	$ 137,924.41	$ 3,207.54	0.02%
COPAXONE	IMMUNOMODULATORY AGENTS	26	$ 132,097.98	$ 5,080.69	0.01%
OXYCONTIN	OPIATE AGONISTS	387	$ 124,169.89	$ 320.85	0.18%
BUDESONIDE	CORTICOSTEROIDS (RESPIRATORY TRACT)	385	$ 124,103.97	$ 322.35	0.18%
SEROQUEL XR	ANTIPSYCHOTIC AGENTS	205	$ 118,498.39	$ 578.04	0.10%
GLEEVEC	ANTINEOPLASTIC AGENTS	9	$ 113,341.40	$ 12,593.49	0.00%
LANTUS	INSULINS	264	$ 112,804.21	$ 427.29	0.12%
VENTOLIN HFA	BETA-ADRENERGIC AGONISTS	2,143	$ 109,366.89	$ 51.03	1.00%
NORDITROPIN FLEXPRO	PITUITARY	38	$ 107,278.29	$ 2,823.11	0.02%
PROAIR HFA	BETA-ADRENERGIC AGONISTS	1,653	$ 91,704.16	$ 55.48	0.77%
SPIRIVA	ANTIMUSCARINICS/ANTISPASMODICS	262	$ 86,291.58	$ 329.36	0.12%
CEFDINIR	CEPHALOSPORINS	1,756	$ 85,717.56	$ 48.81	0.82%
AZITHROMYCIN	MACROLIDES	4,534	$ 84,915.31	$ 18.73	2.11%
INVEGA	ANTIPSYCHOTIC AGENTS	82	$ 84,760.32	$ 1,033.66	0.04%
JANUVIA	DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS	254	$ 84,649.92	$ 333.27	0.12%
TECFIDERA	IMMUNOMODULATORY AGENTS	14	$ 83,906.13	$ 5,993.30	0.01%
VIMPAT	ANTICONVULSANTS, MISCELLANEOUS	133	$ 82,401.32	$ 619.56	0.06%
ONETOUCH ULTRA TEST STRIPS	DIABETES MELLITUS	578	$ 78,590.37	$ 135.97	0.27%
TRUVADA	ANTIRETROVIRALS	54	$ 77,431.80	$ 1,433.92	0.03%
AFINITOR	ANTINEOPLASTIC AGENTS	7	$ 77,015.75	$ 11,002.25	0.00%
MONTELUKAST SODIUM	LEUKOTRIENE MODIFIERS	3,671	$ 76,014.14	$ 20.71	1.70%
ESOMEPRAZOLE MAGNESIUM	PROTON-PUMP INHIBITORS	306	$ 75,980.40	$ 248.30	0.14%
KALYDECO	CYSTIC FIBROSIS (CFTR) POTENTIATORS	3	$ 74,855.88	$ 24,951.96	0.00%
ADVAIR HFA	CORTICOSTEROIDS (RESPIRATORY TRACT)	244	$ 74,294.12	$ 304.48	0.11%
GENOTROPIN	PITUITARY	21	$ 69,638.58	$ 3,316.12	0.01%
HUMIRA	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	19	$ 68,728.96	$ 3,617.31	0.01%
RISPERDAL CONSTA	ANTIPSYCHOTIC AGENTS	49	$ 64,794.79	$ 1,322.34	0.02%
TOTAL TOP 50		41,488	$ 9,153,906.25	$ 220.64	19.27%

Total Rx Claims From 10/01/2015 - 12/31/2015	215,327

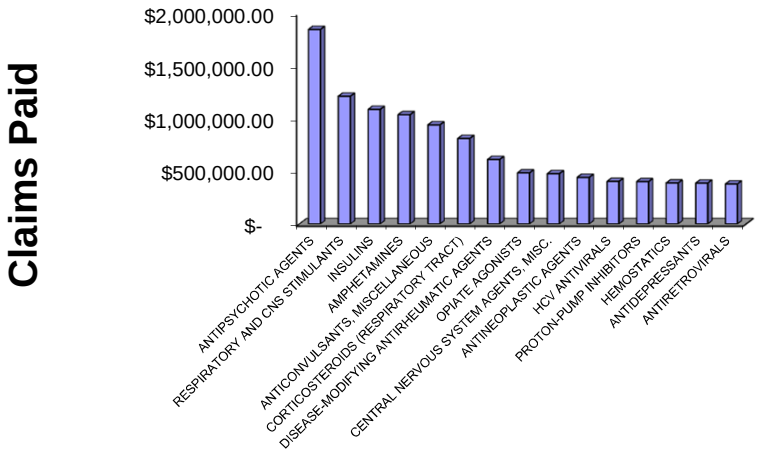
SOUTH DAKOTA MEDICAID
Cost Management Analysis

TOP 15 THERAPEUTIC CLASSES BY TOTAL COST OF CLAIMS FROM 10/01/2015 - 12/31/2015

AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
ANTIPSYCHOTIC AGENTS	6,931	$ 1,844,415.37	$ 266.11	3.22%
RESPIRATORY AND CNS STIMULANTS	7,054	$ 1,212,895.81	$ 171.94	3.28%
INSULINS	2,576	$ 1,088,564.25	$ 422.58	1.20%
AMPHETAMINES	6,472	$ 1,038,061.24	$ 160.39	3.01%
ANTICONVULSANTS, MISCELLANEOUS	9,920	$ 941,878.44	$ 94.95	4.61%
CORTICOSTEROIDS (RESPIRATORY TRACT)	3,147	$ 812,693.80	$ 258.24	1.46%
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	188	$ 612,814.25	$ 3,259.65	0.09%
OPIATE AGONISTS	13,516	$ 485,327.50	$ 35.91	6.28%
CENTRAL NERVOUS SYSTEM AGENTS, MISC.	3,210	$ 478,034.41	$ 148.92	1.49%
ANTINEOPLASTIC AGENTS	484	$ 443,162.96	$ 915.63	0.22%
HCV ANTIVIRALS	13	$ 404,120.70	$ 31,086.21	0.01%
PROTON-PUMP INHIBITORS	6,496	$ 402,181.56	$ 61.91	3.02%
HEMOSTATICS	18	$ 389,516.34	$ 21,639.80	0.01%
ANTIDEPRESSANTS	19,497	$ 388,924.45	$ 19.95	9.05%
ANTIRETROVIRALS	274	$ 379,560.32	$ 1,385.26	0.13%
TOTAL TOP 15	79,796	$ 10,922,151.40	$ 136.88	37.06%

Total Rx Claims From 10/01/2015 - 12/31/2015	215,327

Top 15 Therapeutic Classes
Based on Total Cost of Claims



SD Medicaid Hydrocodone Utilization					
02/01/15 - 01/31/16					
Label Name	**Rx Num**	**Qty Dispensed**	**Avg Qty/Script**	**Total Reimb Amt**	**Avg Cost/Script**
HYDROCODON-ACETAMIN 7.5-325/15	1331	381350	287	$76,840.38	$57.73
HYDROCODON-ACETAMINOPH 7.5-300	6	308	51	$431.87	$71.98
HYDROCODON-ACETAMINOPH 7.5-325	1872	144343	77	$48,344.65	$25.83
HYDROCODON-ACETAMINOPHEN 5-300	28	831	30	$958.50	$34.23
HYDROCODON-ACETAMINOPHEN 5-325	15478	660369	43	$270,833.99	$17.50
HYDROCODON-ACETAMINOPHN 10-300	38	4420	116	$9,149.58	$240.78
HYDROCODON-ACETAMINOPHN 10-325	4526	421795	93	$177,678.40	$39.26
HYDROCODON-ACETAMINOPHN 10-500	1	30	30	$7.72	$7.72
HYSINGLA ER 20 MG TABLET	10	256	26	$1,789.76	$178.98
HYSINGLA ER 30 MG TABLET	20	392	20	$3,959.93	$198.00
HYSINGLA ER 40 MG TABLET	9	268	30	$3,628.08	$403.12
HYSINGLA ER 60 MG TABLET	4	120	30	$2,245.64	$561.41
LORTAB 10 MG-300 MG/15 ML ELXR	32	6378	199	$2,692.34	$84.14
NORCO 5-325 TABLET	1	30	30	$13.07	$13.07
VICODIN 5-300 MG TABLET	42	1514	36	$2,279.46	$54.27
VICODIN ES 7.5-300 MG TABLET	12	1905	159	$3,128.09	$260.67
VICODIN HP 10-300 MG TABLET	2	204	102	$481.51	$240.76
ZOHYDRO ER 10 MG CAPSULE	1	60	60	$389.01	$389.01
8627 recipients	**23413**	**1624573**		**$604,851.98**	

SD Medicaid Hydrocodone Utilization

Top 50 Patients By Script Count

Recipient	Medication	# Scripts	Avg Qty/Script	Sum of $ Paid	Avg # Scripts/Month	Avg Tablets/Day
1	HYDROCODON-ACETAMINOPHN 10-325	43	40	767.25	3.6	4.75
2	HYDROCODON-ACETAMINOPHN 10-325	39	56	990.42	3.3	6.72
3	HYDROCODON-ACETAMINOPHEN 5-325	39	26	500.68	3.3	2.78
4	HYDROCODON-ACETAMINOPHN 10-325	37	50	850.58	3.1	5.56
5	HYDROCODON-ACETAMINOPHN 10-325	36	101	1572.88	3.0	10
6	HYDROCODON-ACETAMINOPHEN 5-325	36	40	633.59	3.0	4
7	HYDROCODON-ACETAMINOPHEN 5-325	35	56	756.61	2.9	5.45
8	HYDROCODON-ACETAMINOPHEN 5-325	35	44	623.8	2.9	4.28
9	HYDROCODON-ACETAMINOPHN 10-325	34	42	718.98	2.8	5.95
10	HYDROCODON-ACETAMIN 7.5-325/15	33	400	2797.61	2.8	36.71
11	HYDROCODON-ACETAMINOPH 7.5-325	33	74	1007.21	2.8	6.78
12	HYDROCODON-ACETAMINOPHN 10-325	32	51	503.17	2.7	5.4
13	HYDROCODON-ACETAMINOPHN 10-325	32	49	718.02	2.7	4.34
14	HYDROCODON-ACETAMINOPHEN 5-325	31	28	392	2.6	3.21
15	HYDROCODON-ACETAMINOPHN 10-325	31	130	1666.47	2.6	11.17
16	HYDROCODON-ACETAMINOPHN 10-325	30	70	451.15	2.5	8.71
17	HYDROCODON-ACETAMINOPHEN 5-325	29	20	261.07	2.4	1.61
18	HYDROCODON-ACETAMINOPH 7.5-325	29	46	485.2	2.4	3.71
19	HYDROCODON-ACETAMINOPHN 10-325	29	60	797.33	2.4	6.5
20	HYDROCODON-ACETAMINOPH 7.5-325	28	57	645.66	2.3	4.4
21	HYDROCODON-ACETAMINOPHEN 5-325	28	40	492.78	2.3	3.68
22	HYDROCODON-ACETAMINOPH 7.5-325	28	30	757.36	2.3	2.3
23	HYDROCODON-ACETAMINOPHEN 5-325	28	21	282.35	2.3	1.78
24	HYDROCODON-ACETAMINOPHN 10-325	28	51	691.21	2.3	4
25	HYDROCODON-ACETAMINOPHEN 5-325	28	110	1198.03	2.3	8.58
26	HYDROCODON-ACETAMINOPHN 10-325	27	57	652.59	2.3	4.26
27	HYDROCODON-ACETAMINOPHN 10-325	27	84	938.47	2.3	6.11
28	HYDROCODON-ACETAMINOPHEN 5-325	27	67	673.26	2.3	5
29	HYDROCODON-ACETAMINOPHEN 5-325	27	60	600.55	2.3	4
30	HYDROCODON-ACETAMINOPH 7.5-325	26	28	342.03	2.2	2
31	HYDROCODON-ACETAMINOPHN 10-325	26	110	1233.19	2.2	8.65
32	HYDROCODON-ACETAMINOPHN 10-325	26	42	513.72	2.2	3
33	HYDROCODON-ACETAMINOPHN 10-325	26	70	812.71	2.2	5.05
34	HYDROCODON-ACETAMINOPHEN 5-325	26	60	575.49	2.2	7.05
35	HYDROCODON-ACETAMINOPHEN 5-325	26	48	498.63	2.2	3.44
36	HYDROCODON-ACETAMINOPHEN 5-325	26	90	882.68	2.2	6.5
37	HYDROCODON-ACETAMINOPHEN 5-325	25	50	504.01	2.1	4.18
38	HYDROCODON-ACETAMINOPHN 10-325	25	84	1190.3	2.1	5.22
39	HYDROCODON-ACETAMINOPHEN 5-325	25	47	425.31	2.1	3.28
40	HYDROCODON-ACETAMINOPHN 10-325	25	50	538.21	2.1	3.5
41	HYDROCODON-ACETAMINOPH 7.5-325	25	120	932.91	2.1	8.13

SD Medicaid Hydrocodone Utilization

Top 50 Patients By Script Count

Recipient	Medication	# Scripts	Avg Qty/Script	Sum of $ Paid	Avg # Scripts/Month	Avg Tablets/Day
42	HYDROCODON-ACETAMINOPHEN 5-325	25	134	1354.97	2.1	9.33
43	HYDROCODON-ACETAMINOPHEN 5-325	25	54	493.61	2.1	3.77
44	HYDROCODON-ACETAMINOPHEN 5-325	24	36	341.65	2.0	4.09
45	HYDROCODON-ACETAMINOPHN 10-325	24	200	1950.68	2.0	13.33
46	HYDROCODON-ACETAMINOPH 7.5-325	24	60	498.72	2.0	4
47	HYDROCODON-ACETAMINOPHN 10-325	24	60	640.38	2.0	4
48	HYDROCODON-ACETAMINOPHEN 5-325	24	39	348.96	2.0	3.12
49	HYDROCODON-ACETAMINOPHEN 5-325	23	39	376.56	1.9	3.32
50	HYDROCODON-ACETAMINOPHN 10-325	23	98	953.17	1.9	6.28

PCSK9 INHIBITORS
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 PCSK9 inhibitor must meet the following criteria:

- Diagnosis of HeFH or HoFH AND clinical atherosclerotic cardiovascular disease with supporting documentation.
- Must be 18 years of age or older for the diagnosis of HeFH and clinical atherosclerotic cardiovascular disease or must be 13 years of age or older for the diagnosis of HoFH (Repatha only).
- Must be on high dose statin therapy for at least 3 months.

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:	SPECIALIST INVOLVED IN THERAPY:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug:	Diagnosis for this Request: Provide supporting documentation of diagnosis: Current statin therapy: Member's baseline LDL-C_____ Current LDL-C_____ Goal LDL-C:_____

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)	

LYRICA
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 Lyrica must meet the following criteria:

- Post herpetic neuralgia (PHN), fibromyalgia, or diabetic peripheral neuropathy (DPN) – must have tried and failed tricyclic antidepressants and gabapentin.
- Partial onset seizures – must be used as adjunctive therapy.
- Neuropathic pain associated with spinal cord injury – must have clinically documented diagnosis.

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:	Diagnosis for this Request:	Trial: Start Date: End Date: Trial: 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)

OTREXUP
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 Otrexup must meet the following criteria:

Patient must be clinically diagnosed with:

- Severe, active rheumatoid arthritis (RA) or polyarticular juvenile idiopathic arthritis (pJIA) and intolerant of or had an inadequate response to first-line therapy
- Severe, recalcitrant, disabling psoriasis in adults who are not adequately responsive to other forms of therapy

Patient must have tried and failed methotrexate.

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:	Diagnosis for this Request:	Trial: 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)

DURLAZA
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 Durlaza must meet the following criteria:

- Patient must have a diagnosis of chronic coronary artery disease, ischemic stroke, or transient ischemic attack.
- Patient must try and fail immediate release aspirin and the prescriber must document a clinical rationale why this failure would not occur with the extended-release product.

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:	Diagnosis for this Request:	Trial: 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#:

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#:

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)	

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)	

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)	

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)	

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)	

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)	

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)	

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)	

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, Avapro, Avalide, Azor, Benicar, Diovan, Edarbi, Exforge, Hyzaar, Micardis, Teveten, Tribenzor, Twynsta, Valturna.

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)	

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)

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)

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)	

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)	

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)	

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)

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)

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)	

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)	

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)	

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** □ **Detrol** □ **Sanctura** □ **Vesicare** □ **Sanctura XR**	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)

HARVONI
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 Harvoni must meet the following criteria:

- Patient must be ≥ 18 years old.
- Must have a diagnosis of chronic hepatitis C (genotype 1).
- Liver biopsy confirming a Metavir score of F3 or F4, unless medically contraindicated; or documentation of severe extrahepatic manifestations of hepatitis C infection.
- Must be prescribed by a hepatologist, gastroenterologist, or infectious disease specialist.
- Absence of renal impairment (eGFR must be >30mL/min/1.73m^2) and absence of end stage renal disease (ESRD).
- Documentation showing that patient is drug and alcohol free for the past 6 months.
- The concomitant use of Harvoni and P-gp inducers (rifampin, St. John's wort), certain anticonvulsants, certain antiretrovirals, and rosuvastatin is not recommended.

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:	NAME OF SPECIALIST:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug:	Diagnosis for this request:	Documented liver fibrosis:	Patient is drug and alcohol free for past 6 months:
□ **Harvoni** Dosage: _____	Genotype:	□ YES □ NO	□ YES □ NO eGFR:

Has the patient been previously treated for chronic hepatitis C? □ YES □ NO If yes, please indicate past treatment regimen(s), dates of treatment, and response to therapy:	Baseline HCV RNA: HCV RNA 4 weeks after starting therapy:
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)	

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)	

HETLIOZ
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 Hetlioz must meet the following criteria:

- Patient must have an FDA approved indication.
- Patient must try and fail a generic sedative-hypnotic.

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: □ **Hetlioz**	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)

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)	

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)	

LUZU
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 Luzu must meet the following criteria:

- Patient must have an FDA approved indication.
- Patient must be 18 years of age or older.
- Patient must have documented history of failure of two topical antifungal agents (clotrimazole, econazole) and two oral antifungal agents (terbinafine, fluconazole, itraconazole).

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: □ **Luzu**	Diagnosis for this request:
Failed therapy (Drug and Dose) 1. 2. 3. 4.	Start Date: End Date: 1. 2. 3. 4.
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)

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)	

MEDICATIONS > $5,000
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 medications that cost >$5,000 must meet the following criteria:

- Patient must have an FDA approved indication for the medication requested
- May require additional documentation.

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:	Indication (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)

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)	

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)	

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 □ HYSINGLA □ FENTORA □ BUTRANS □ ABSTRAL □ ONSOLIS □ LAZANDA □ SUBSYS □ ZOHYDRO

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)	

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** □ **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)	

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)	

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)

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)					

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: □ **Nuvigil _____** □ **Provigil_____**	**FDA approved indication for this request:** □ **Narcolepsy** □ **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)	

OLYSIO
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 Olysio must meet the following criteria:

- Patient must be ≥ 18 years old.
- Must have a diagnosis of chronic hepatitis C, genotype 1.
- Liver biopsy confirming a Metavir score of F3 or F4, unless medically contraindicated; or documentation of severe extrahepatic manifestations of hepatitis C infection.
- Must be prescribed by a hepatologist, gastroenterologist, or infectious disease specialist.
- Must be used in combination with pegylated interferon and ribavirin. **(must not be used as monotherapy)**
- Alternative therapy should be considered for patients infected with HCV genotype 1a containing the Q80K polymorphism.
- Female patients must have a negative pregnancy test within 30 days prior to initiation of therapy and monthly during treatment.
- Documentation showing that patient is drug and alcohol free for the past 6 months.

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:	NAME OF SPECIALIST:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug: □ **Olysio** Dosage: _____	Presence of Q80K polymorphism? □ YES □ NO	Diagnosis for this request: Genotype:	Patient is drug and alcohol free for past 6 months: □ YES □ NO
	Documented liver fibrosis:	Pegylated interferon dose: Ribavirin dose:	Negative pregnancy test in the past 30 days □ YES □ NO
Has the patient been previously treated for chronic hepatitis C? □ YES □ NO If yes, please indicate past treatment regimen(s), dates of treatment, and response to therapy:			Baseline HCV RNA: HCV RNA 4 weeks after starting therapy:
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)

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)	

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)

ORAL ALLERGEN EXTRACTS
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 oral allergen extracts must meet the following criteria:

- Patient must have the FDA approved indication for the drug requested.
- Diagnosis confirmed by positive skin test or *in vitro* testing for pollen-specific IgE antibodies.
- History of failure, contraindication, or intolerance to two of the following: oral antihistamine, intranasal antihistamine, intranasal corticosteroid, or leukotriene inhibitors.
- History of failure or intolerance to subcutaneous allergen immunotherapy (allergy shots).
- Patient must not have severe, unstable, or uncontrolled asthma.

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:	Diagnosis for this Request:	History of Failure:
□ GRASTEK	□ GRASS POLLEN-INDUCED ALLERGIC RHINITIS	**1.**
□ ORALAIR	□ RAGWEED POLLEN-INDUCED ALLERGIC RHINITIS	**2.**
□ RAGWITEK		**3.**
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)	

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, Eliquis, or Savaysa must meet the following criteria:

- Patients must have an FDA approved indication.

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** □ **Savaysa**	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)	

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)	

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, rapeprazole 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, rabeprazole or lansoprazole for a minimum of 14 days. 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 (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: / /

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)	

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)

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)

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)			

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)	

SOVALDI
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 Sovaldi must meet the following criteria:

- Patient must be ≥ 18 years old.
- Must have a diagnosis of chronic hepatitis C (genotypes 1, 2, 3, or 4).
- Liver biopsy confirming a Metavir score of F3 or F4, unless medically contraindicated; or documentation of severe extrahepatic manifestations of hepatitis C infection.
- Must be prescribed by a hepatologist, gastroenterologist, or infectious disease specialist.
- Must be used in combination with ribavirin or in combination with pegylated interferon and ribavirin. **(must not be used as monotherapy)**
- Female patients must have a negative pregnancy test within 30 days prior to initiation of therapy and monthly during treatment.
- Absence of renal impairment (eGFR must be >30mL/min/1.73m^2) and absence of end stage renal disease (ESRD).
- Documentation showing that patient is drug and alcohol free for the past 6 months.

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:	NAME OF SPECIALIST:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug: □ **Sovaldi** Dosage: _____	Diagnosis for this request: Genotype:	Documented liver fibrosis:	Patient is drug and alcohol free for past 6 months: □ YES □ NO	
		Pegylated interferon dose: Ribavirin dose:	Negative pregnancy test in the past 30 days: □ YES □ NO	eGFR:

Has the patient been previously treated for chronic hepatitis C? □ YES □ NO If yes, please indicate past treatment regimen(s), dates of treatment, and response to therapy:	Baseline HCV RNA: HCV RNA 4 weeks after starting therapy:
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)	

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)	

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, Cosentyx, Kineret, Cimzia, 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**
□ **Cosentyx** _____	□ **Juvenile Idiopathic Arthritis**
□ **Enbrel** _____	□ **Plaque Psoriasis**
□ **Kineret** _____	□ **Ankylosing Spondylitis**
□ **Humira** _____	□ **Psoriatic Arthritis**
□ **Cimzia** _____	□ **Crohn's Disease**
□ **Simponi** _____	□ **Ulcerative Colitis**
□ **Actemra** _____	**Subspecialist Involved in Therapy:**
□ **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)	

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)

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)

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.

- **Sumatriptan, rizatriptan, and zolmitriptan do 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 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)	

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)	

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)				

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)	

VIEKIRA
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 Viekira must meet the following criteria:

- Patient must be 18 years old.
- Must have a diagnosis of chronic hepatitis C (genotype 1).
- Liver biopsy confirming a Metavir score of F3 or F4, unless medically contraindicated; or documentation of severe extrahepatic manifestations of hepatitis C infection.
- Must be prescribed by a hepatologist, gastroenterologist, or infectious disease specialist.
- Documentation showing that patient is drug and alcohol free for the past 6 months
- Viekira is contraindicated in patients with moderate to severe hepatic impairment.
- Viekira is contraindicated with the following drug classes: alpha 1-adrenoreceptor antagonist (alfuzosin); anti-gout (colchicine); anticonvulsants (carbamazepine, phenytoin, phenobarbital); antihyperlipidemic agent (gemfibrozil); antimycobacterial (rifampin); ergot derivatives (ergotamine, dihydroergotamine, ergonovine, methylergonovine); ethinyl estradiol containing products (such as combined oral contraceptives); herbal products (St. John's wort); HMG-CoA reductase inhibitors (lovastatin, simvastatin); neuroleptics (pimozide); non-nucleoside reverse transcriptase inhibitor (efavirenz); phosphodiesterase-5 inhibitor (sildenafil); sedative/hypnotics (triazolam, orally administered midazolam).

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:	NAME OF SPECIALIST:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug:	Diagnosis for this request:	Documented liver fibrosis:	Patient is drug and alcohol free for past 6 months:
Viekira	Genotype:	YES NO	YES NO
Dosage: _____		Ribavirin dose:	

Has the patient been previously treated for chronic hepatitis C? YES NO If yes, please indicate past treatment regimen(s), dates of treatment, and response to therapy:	Baseline HCV RNA: HCV RNA 4 weeks after starting therapy:
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)	

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)	

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)	

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)

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)	

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)	

PRODUCT DETAILS OF NARCAN NASAL SPRAY

INDICATIONS AND USE:
Narcan nasal spray is indicated for the emergency treatment of known or suspected opioid overdose, as manifested by respiratory and/or central nervous system depression. Narcan nasal spray is intended for immediate administration as emergency therapy in settings where opioids may be present.

ADMINISTRATION:

- Administer Narcan nasal spray as quickly as possible to prevent prolonged respiratory depression.
- Additional doses may be required until emergency medical assistance becomes available.
- Each Narcan nasal spray contains a single dose of naloxone and cannot be reused.
- Re-administer with a new nasal spray ever 2-3 minutes if the patient does not respond or responds and then relapses.
- Administer in alternate nostrils with each dose.
- Recommended initial dose is one spray by intranasal administration delivering 4 mg of naloxone hydrochloride.

DOSAGE FORM AND STRENGTHS:
Nasal spray: 4 mg of naloxone hydrochloride in 0.1 mL

WARNINGS AND PRECAUTIONS:

- Risk of recurrent respiratory and CNS depression
- Risk of limited efficacy with partial agonists or mixed agonists/antagonists
- Precipitation of severe opioid withdrawal
- Risk of cardiovascular effects

ADVERSE REACTIONS:
The following adverse reactions were observed in a clinical study: increased blood pressure, musculoskeletal pain, headache, nasal dryness, nasal edema, nasal congestion, and nasal inflammation.

References:

1. Narcan nasal spray [package insert]. Radnor, PA: Adapt Pharma, Inc., November 2015.

PRODUCT DETAILS OF TIVORBEX

INDICATIONS AND USE:
Tivorbex is a nonsteroidal anti-inflammatory drug (NSAID) indicated for the treatment of mild to moderate acute pain in adults.

DOSAGE AND ADMINISTRATION:

- The dosage is 20 mg orally three times daily or 40 mg orally two or three times daily.
- Use the lowest effective dose for the shortest duration consistent with individual patient treatment goals.

DOSAGE FORM AND STRENGTHS:
Capsules: 20 mg or 40 mg

CONTRAINDICATIONS:

- History of asthma, urticaria, or other allergic-type reactions after taking aspirin or other NSAIDs.
- Perioperative pain in the setting of CABG surgery.

WARNINGS AND PRECAUTIONS:

- Serious and potentially fatal cardiovascular (CV) thrombotic events, myocardial infarction, and stroke can occur with NSAID treatment. Patients with known CV disease or risk factors for CV disease may be at greater risk. Use the lowest effective dose for the shortest duration possible.
- Serious gastrointestinal (GI) adverse events including bleeding, ulceration, and perforation, which can be fatal. Prescribe with caution in patients with prior history of ulcer disease or GI bleeding.
- Elevation of one or more liver tests and severe hepatic reactions. Measure transaminases (ALT and AST) periodically in patients receiving long-term therapy with Tivorbex. Discontinue if abnormal liver tests persist or worsen or if clinical signs and symptoms of liver disease develop.
- New onset or worsening hypertension. Monitor blood pressure closely.
- Fluid retention and edema.
- Renal papillary necrosis and other renal injury with long-term use.
- Anaphylactic reactions may occur in patients with the aspirin triad or without prior exposure to indomethacin.

- Indomethacin may aggravate depression or other psychiatric disturbances, epilepsy, and Parkinsonism.
- Serious adverse skin events such as exfoliative dermatitis, Stevens - Johnson syndrome, and toxic epidermal necrolysis, which can be fatal.

ADVERSE REACTIONS:

Most common adverse reactions in clinical trials (incidence ≥ 2% in Tivorbex 20 mg and 40 mg groups) include: nausea, post-procedural edema, headache, dizziness, vomiting, post-procedural hemorrhage, constipation, pruritus, diarrhea, dyspepsia, post-procedural swelling, presyncope, rash, abdominal pain (upper), somnolence, pruritus generalized, hyperhidrosis, decreased appetite, hot flush, and syncope.

DRUG INTERACTIONS:

- Co-administration with indomethacin may reduce the effect of antihypertensive agents. Concomitant use in patients with compromised renal function may result in further deterioration of renal function.
- Concomitant administration of indomethacin and anticoagulants and platelet inhibitors (e.g., aspirin) is not generally recommended because of the potential of increased adverse effects including increased GI bleeding.

References:

1. Tivorbex [package insert]. Philadelphia, PA: Iroko Pharmaceuticals,LLC. February 2014.

PRODUCT DETAILS OF NUCALA

INDICATIONS AND USE:
Nucala is an interleukin-5 antagonist monoclonal antibody (IgG1 kappa) indicated for add-on maintenance treatment of patients with severe asthma aged 12 years and older, and with an eosinophilic phenotype. Nucala is not for treatment of other eosinophilic conditions and not for relief of acute bronchospasm or status asthmaticus.

ADMINISTRATION:

- 100 mg administered subcutaneously once every 4 weeks

DOSAGE FORM AND STRENGTHS:
Injection: 100 mg of lyophilized powder in a single-dose vial for reconstitution.

WARNINGS AND PRECAUTIONS:

- Hypersensitivity reactions.
- Do not use to treat acute bronchospasm or status asthmaticus.
- Herpes zoster infections have occurred in patients receiving Nucala.
- Do not discontinue systemic or inhaled corticosteroids abruptly upon initiation of therapy with Nucala. Decrease corticosteroids gradually, when appropriate.
- Treat patients with pre-existing helminth infections before therapy with Nucala. If patients become infected while receiving Nucala and do not respond to anti-helminth treatment, discontinue Nucala until parasitic infection resolves.

ADVERSE REACTIONS:
Most common adverse reactions (incidence greater than or equal to 5%) include headache, injection site reactions, back pain, and fatigue.

References:

1. Nucala [package insert]. Philadelphia, PA: GlaxoSmithKline LLC; November 2015.

PRODUCT DETAILS OF VARUBI

INDICATIONS AND USE:
Varubi is a substance P/neurokinin 1 (NK1) receptor antagonist indicated in combination with other antiemetic agents in adults for the prevention of delayed nausea and vomiting associated with initial and repeat courses of emetogenic cancer chemotherapy, including, but not limited to, highly emetogenic chemotherapy.

DOSAGE AND ADMINISTRATION:
- The recommended dosage is 180 mg rolapitant administered approximately 1 to 2 hours prior to the start of chemotherapy.
- Administer in combination with dexamethasone and a 5-HT_3 receptor antagonist.

DOSAGE FORMS:
- Tablets: 90 mg of rolapitant

CONTRAINDICATIONS:
- Concurrent use with thioridazine, a CYP2D6 substrate.

WARNINGS AND PRECAUTIONS:
- Interaction with CYP2D6 substrates with a narrow therapeutic index – the inhibitory effect of a single dose of Varubi on CYP2D6 lasts at least 7 days and may last longer. Avoid use of pimozide; monitor for adverse reactions if concomitant use with other CYP2D6 substrates with a narrow therapeutic index cannot be avoided.

ADVERSE REACTIONS:
- Cisplatin-based highly emetogenic chemotherapy – neutropenia and hiccups.
- Moderately emetogenic chemotherapy and combinations of anthracycline and cyclophosphamide – decreased appetite, neutropenia, and dizziness.

References:

1. Varubi [package insert]. Waltham, MA: Tesaro, Inc.; September 2015.

PRODUCT DETAILS OF ZURAMPIC

INDICATIONS AND USE:
Zurampic is a URAT1 inhibitor indicated in combination with a xanthine oxidase inhibitor for the treatment of hyperuricemia associated with gout in patients who have not achieved target serum uric acid levels with a xanthine oxidase inhibitor alone. Zurampic is not recommended for the treatment of asymptomatic hyperuricemia and should not be used as monotherapy.

DOSAGE AND ADMINISTRATION:

- The dosage is 200 mg once daily in combination with a xanthine oxidase inhibitor, including allopurinol or febuxostat. The maximum daily dose is 200 mg.
- Failure to take Zurampic with a xanthine oxidase inhibitor may increase the risk of renal adverse reactions.
- Zurampic tablets should be taken in the morning with food and water.
- Patients should be instructed to stay well hydrated.
- Assess renal function before initiating Zurampic.

DOSAGE FORM AND STRENGTHS:
Tablets: 200 mg

CONTRAINDICATIONS:

- Severe renal impairment, end stage renal disease, kidney transplant recipients, or patients on dialysis.
- Tumor lysis syndrome or Lesch-Nyhan syndrome.

WARNINGS AND PRECAUTIONS:

- Renal events – Adverse reactions related to renal function have occurred after initiating Zurampic. A higher incidence was observed at the 400 mg dose, with the highest incidence occurring with monotherapy use. Monitor renal function at initiation and during therapy, particularly in patients with eCLcr below 60 mL/min, and evaluate for signs and symptoms of acute uric acid nephropathy.
- Cardiovascular events – Major adverse cardiovascular events were observed with Zurampic; a causal relationship has not been established.

ADVERSE REACTIONS:

Most common adverse reactions in 12-month controlled clinical trials (occurring in greater than or equal to 2% of patients treated with Zurampic in combination with a xanthine oxidase inhibitor and more frequently than on a xanthine oxidase inhibitor alone) were headache, influenza, blood creatinine increased, and gastroesophageal reflux diseas.

DRUG INTERACTIONS:

- Moderate CYP2C9 inhibitors – use with caution.
- Sensitive CYP3A substrates – monitor for efficacy of the CYP3A substrate.

References:

1. Zurampic [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals, LP; December 2015.