South Dakota Department of Social Services

Medicaid P&T Committee Meeting

March 2, 2012

DSS

Strong Families - South Dakota's Foundation and Our Future

STATE OF SOUTH DAKOTA
OFFICE OF THE GOVERNOR
EXECUTIVE ORDER 2011-23

WHEREAS, The state of South Dakota recognizes that outpatient prescription drugs are an essential component of patient care; and,

WHEREAS, The state of South Dakota provides prescription drug coverage as a health benefit for its citizens who qualify for the Medicaid Program under the provisions of SDCL 28-6; and,

WHEREAS, The number of eligibles for the Medicaid Program continues to increase each year; and,

WHEREAS, The state of South Dakota recognizes efforts must be made to establish a plan that will provide for the effective continuation of the prescription drug coverage benefit; and,

WHEREAS, The state of South Dakota recognizes there is a need to address the high costs of prescription drugs, the increased expenditures for those prescription drugs, and the need to find ways to control the costs of prescription drugs while ensuring the needs of recipients are being met; and,

WHEREAS, The state of South Dakota recognizes that requiring a prior authorization program for coverage of a drug can be an effective tool for helping ensure beneficiaries have access to medically necessary medication in a clinically appropriate and cost-effective manner; and,

WHEREAS, Requiring a prior authorization program for coverage of a drug can help control prescription drug costs while protecting the consumer's needs;

IT IS. THEREFORE, BY EXECUTIVE ORDER, directed that the South Dakota Medicaid Pharmaceutical and Therapeutics (P & T) Committee be established and authorized to function in compliance with the following sections of this order.

General Provisions

Section 1. The name of the committee is the South Dakota Medicaid Pharmaceutical and Therapeutics (P & T) Committee.

Section 2. The governor of the state of South Dakota may appoint as many members as he deems necessary to accomplish the goals of this committee.

Section 3. The South Dakota Medicaid P & T Committee shall work with the Department of Social Services in addressing the high costs of prescription drugs, the increased expenditures for those prescription drugs, and the need to find ways to control the costs of prescription drugs while ensuring the needs of recipients are being met.

Section 4. The South Dakota Medicaid P & T Committee shall provide expertise and direction to the Department of Social Services in matters relating to the drugs being used by our recipient population including, but not limited to: establishing a prior authorization program, instituting quantity limits, establishing restrictions on early refills, mandating the use of generic drugs, amending the co-pay requirements, investigating state buying pools, considering the coverage of certain over-the-counter medications, developing a preferred drug list, and working with a pharmacy benefit manager to establish a prior authorization program for certain selected drugs.

Section 5. The South Dakota Medicaid P & T Committee shall make recommendations to the Department of Social Services in the development and maintenance of a list of drugs that will require prior authorization before being dispensed for any medically accepted indication.

Section 6. The South Dakota Medicaid P & T Committee shall ensure that interested parties have an opportunity to present public testimony with information or evidence supporting inclusion of a product for prior authorization.

Section 7. The South Dakota Medicaid P & T Committee shall analyze and consider the recommendations of interested parties and the potential impact of a decision to require prior authorization of a drug for individuals covered by the Medicaid Program under the provisions of SDCL Chapter 28-6.

Section 8. The South Dakota Medicaid P & T Committee shall develop its recommendations of drugs to be placed on the prior authorization program by considering the clinical efficacy, safety, and cost effectiveness of a product.

Section 9. The South Dakota Medicaid P & T Committee shall be administered by the South Dakota Department of Social Services.

Section 10. The South Dakota Medicaid P & T Committee shall meet on a semiannual basis, or more often at the discretion of the Secretary of the Department of Social Services.

Section 11. Each member of the South Dakota Medicaid P & T Committee may receive per diem compensation and allowable reimbursement for expenses pursuant to SDCL 4-7-10.4.

Section 12. Executive Order 2005-09 is hereby rescinded.

Dated in Pierre, South Dakota, this Twenty-fourth day of October, 2011.

STATE OF SOUTH DAKOTA · GREAT SEAL · 1889

UNDER GOD THE PEOPLE RULE

Dennis Daugaard

Dennis Daugaard, Governor

Attest:

Jason M. Gant

Jason M. Gant, Secretary of State

DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES
700 Governors Drive
Pierre, South Dakota 57501-2291
(605) 773-3495
FAX (605) 773-5246

SOUTH DAKOTA
MEDICAID P&T COMMITTEE MEETING
AGENDA

Friday, March 2, 2012
1:00 – 3:00 PM

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

Pierre
Capitol Building
DDN Room B
500 E Capitol

Rapid City
Dept of Human Services
111A New York St

Call to Order

Approval of Minutes of Previous Meeting

Prior Authorization Update

Review of Top 15 Therapeutic Categories/Top 25 Drugs

Old Business
- **Review PA forms and criteria**
- **New Oral Anticoagulants (Pradaxa, Xarelto, etc.)**
- **ODT Preparations**

New Business
- **Antipsychotics used as antidepressants**
- **Low-dose Seroquel**
- **Lidoderm**
- **Brilinta**
- **Lorzone**

Oral Presentations and Comments by Manufacturers' Representatives

Next Meeting Date/Adjournment

Minutes of the December 9, 2011
Pharmacy & Therapeutics (P&T) Committee Meeting
SD Department of Social Services, Medical Services Division

Members present
Rick Holm, MD; Debra Farver, PharmD; Dana Darger, RPh; Timothy Soundy, MD; Bill Ladwig, RPh; James Engelbrecht, MD; Michelle Baack, MD; Mikel Holland, MD; Kelly Oehlke, PharmD; Lenny Petrick, PharmD

DSS staff present
Mike Jockheck, RPh

HID staff present
Candace Rieth, PharmD

Administrative Business
The P&T meeting was called to order by D. Darger at approximately 1:00 pm. Introductions of new committee members commenced. The minutes of the September 9, 2011 meeting were presented. D. Farver made a motion to approve. R. Holm seconded the motion. The motion was approved unanimously.

Prior Authorization Update and Statistics
C. Rieth presented an overview of the prior authorization (PA) activity for October 2011. There were a total of 1,783 PAs processed in the month of October, with 98.49% of those requests responded to in less than 8 hours. There were 1,495 (84%) requests received electronically and 288 (16%) requests received by fax.

Analysis of the Top 15 Therapeutic Classes
C. Rieth reviewed the Top 15 Therapeutic Classes by total cost of claims from 07/01/2011 – 09/30/2011. The top five classes were antipsychotics, cerebral stimulants, amphetamines, adrenals, and leukotriene modifiers. The top 15 therapeutic classes make up 40.37% of total claims. C. Rieth also reviewed the top 25 drugs based on total claims cost and number of claims. The top 25 drugs by claims cost make up 12.76% of total claims.

Medications used to treat Hepatitis C Review
The committee placed Incivek and Victrelis on prior authorization at the September meeting. C. Rieth presented the prior authorization form. L. Kolodny, representing Merck, spoke regarding Victrelis. A motion was made by D. Farver to approve the Hepatitis C Virus Medication PA form. M. Baack seconded the motion. The motion was approved unanimously.

ADHD Review
The committee asked that ADHD medications be reviewed at the September meeting. There was no public comment. The committee asked that claims for recipients less than 3 be reviewed. No further action was taken.

Juvisync Review
C. Rieth presented clinical information on Juvisync. This topic was tabled.

Narrow Therapeutic Index Drugs
C. Rieth presented information on narrow therapeutic index drugs. This topic was tabled.

New Oral Anticoagulants Review
C. Rieth presented clinical information for new oral anticoagulants. A. Nicholas, representing Boehringer Ingelheim, spoke regarding Pradaxa. J. Stoffel, representing Janssen Scientific Affairs, spoke regarding

Xarelto. A motion was made by J. Engelbrecht to place oral anticoagulants on prior authorization. R. Holm seconded the motion. The motion passed unanimously.

ODT Review

C. Rieth presented information for orally disintegrating tablets currently available. There was no public comment. The committee asked that more information be brought to the March meeting

The next meeting date is scheduled for March 2, 2012. The location will be updated on the website as soon as possible. A motion was made by B. Ladwig at 2:50 pm to adjourn the SD Medicaid P&T meeting. D. Farver seconded the motion. Motion passed unanimously and the meeting was adjourned.

Time Ratio

Total PAs	Response Under 8 Hours	Response Over 8 Hours	% Under 8 Hours	% Over 8 Hours
2,088	2,047	41	98.04%	1.96%

By Form Type

Form Type	Description	Approve	Deny
ADP	Antidepressant	223	136
ALT	Altabax	2	11
AMB	Ambien CR	6	2
ANF	Anti-Infectives(anti-biotic)	0	1
ANT	Antihistamines	23	66
APS	Antipsychotic	51	34
ARB	ARBS	16	13
CYA	Cyanocobalamin	1	0
DAW	Dispense As Written	8	22
FUN	Antifungals	0	6
GRH	Growth Hormone	5	0
HLM	Head Lice Medication	29	39
MAX	Max Units Override	69	796
NAR	Name Brand Narcotics	6	10
NUC	Opioids	4	7
PPI	Proton Pump Inhibitors	52	82
SMR	Skeletal Muscle Relaxants	0	4
STI	Stimulants	7	7
SUB	Suboxone/Subutex	6	43
TIM	Targeted Immune Modulators	10	19
TRP	Triptans	53	50
ULT	Ultram ER	3	11
UNK	UNKNOWN(online)	0	153
XOL	Xolair	1	1
Totals		575	1513

By Request Type

01/01/12 - 01/31/12	# of Requests	Electronic Requests #	Electronic Requests %	Faxed Requests #	Faxed Requests %
Prior Authorizations:					
Antidepressant	359	262	73%	97	27%
Altabax	13	9	69%	4	31%
Ambien CR	8	8	100%	0	0%
Anti-Infectives(anti-biotic)	1	1	100%	0	0%
Antihistamines	89	76	85%	13	15%
Antipsychotic	85	55	65%	30	35%
ARBS	29	23	79%	6	21%
Cyanocobalamin	1	0	0%	1	100%
Dispense As Written	30	19	63%	11	37%
Antifungals	6	6	100%	0	0%
Growth Hormone	5	0	0%	5	100%
Head Lice Medication	68	29	43%	39	57%
Max Units Override	1,018	966	95%	52	5%
Name Brand Narcotics	16	7	44%	9	56%
Opioids	11	8	73%	3	27%
Proton Pump Inhibitors	134	112	84%	22	16%
Skeletal Muscle Relaxants	4	3	75%	1	25%
Stimulants	14	9	64%	5	36%
Suboxone/Subutex	49	43	88%	6	12%
Targeted Immune Modulators	29	22	76%	7	24%
Triptans	103	87	84%	16	16%
Ultram ER	14	13	93%	1	7%
Xolair	2	0	0%	2	100%
Prior Authorization Totals	2,088	1,758	84%	330	16%

Electronic PAs (unique)

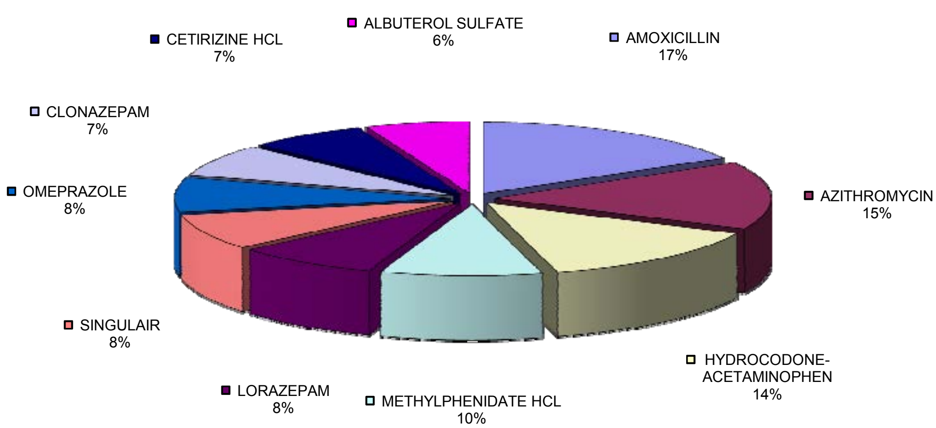
01/01/12 - 01/31/12	# Unique Approved	# Unique Denied	# Unique Incomplete	Unique Total	Approval %	Total Transactions
Prior Authorizations:						
Antidepressant	136	119	0	255	53.30%	262
Altabax	0	8	0	8	0.00%	9
Ambien CR	6	2	0	8	75.00%	8
Anti-Infectives(anti-biotic)	0	1	0	1	0.00%	1
Antihistamines	14	60	0	74	18.90%	76
Antipsychotic	30	25	0	55	54.50%	55
ARBS	10	11	0	21	47.60%	23
Dispense As Written	0	18	0	18	0.00%	19
Antifungals	0	6	0	6	0.00%	6
Head Lice Medication	0	29	0	29	0.00%	29
Max Units Override	30	882	0	912	3.30%	966
Name Brand Narcotics	0	6	0	6	0.00%	7
Opioids	2	6	0	8	25.00%	8
Proton Pump Inhibitors	33	73	0	106	31.10%	112
Skeletal Muscle Relaxants	0	3	0	3	0.00%	3
Stimulants	2	7	0	9	22.20%	9
Suboxone/Subutex	0	38	0	38	0.00%	43
Targeted Immune Modulators	4	15	0	19	21.10%	22
Triptans	41	43	0	84	48.80%	87
Ultram ER	2	10	0	12	16.70%	13
Prior Authorization Totals:	310	1362	0	1672	18.50%	1758

TOP 25 DRUGS BASED ON NUMBER OF CLAIMS FROM 10/01/2011 - 12/31/2011

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
AMOXICILLIN	PENICILLINS	7,640	$ 73,291.18	$ 9.59	3.57%
AZITHROMYCIN	MACROLIDES	7,050	$ 121,563.32	$ 17.24	3.29%
HYDROCODONE-ACETAMINOPHEN	OPIATE AGONISTS	6,359	$ 75,714.41	$ 11.91	2.97%
METHYLPHENIDATE HCL	ANOREX.,RESPIR.,CEREBRAL STIMULANTS,MISC	4,335	$ 623,316.26	$ 143.79	2.03%
LORAZEPAM	BENZODIAZEPINES (ANXIOLYTIC,SEDATIV/HYP)	3,856	$ 30,009.77	$ 7.78	1.80%
SINGULAIR	LEUKOTRIENE MODIFIERS	3,728	$ 507,761.80	$ 136.20	1.74%
OMEPRAZOLE	PROTON-PUMP INHIBITORS	3,578	$ 56,577.99	$ 15.81	1.67%
CLONAZEPAM	BENZODIAZEPINES (ANTICONVULSANTS)	3,363	$ 27,349.92	$ 8.13	1.57%
CETIRIZINE HCL	SECOND GENERATION ANTIHISTAMINES	3,170	$ 53,918.87	$ 17.01	1.48%
ALBUTEROL SULFATE	BETA-ADRENERGIC AGONISTS	2,781	$ 49,064.30	$ 17.64	1.30%
TRAMADOL HCL	OPIATE AGONISTS	2,638	$ 32,296.93	$ 12.24	1.23%
FLUOXETINE HCL	ANTIDEPRESSANTS	2,574	$ 21,615.81	$ 8.40	1.20%
VYVANSE	AMPHETAMINES	2,429	$ 339,022.23	$ 139.57	1.13%
SERTRALINE HCL	ANTIDEPRESSANTS	2,341	$ 20,588.61	$ 8.79	1.09%
CEFDINIR	CEPHALOSPORINS	2,324	$ 89,784.50	$ 38.63	1.09%
LEVOTHYROXINE SODIUM	THYROID AGENTS	2,320	$ 20,400.29	$ 8.79	1.08%
AMOX TR-POTASSIUM CLAVULANATE	PENICILLINS	2,253	$ 62,375.57	$ 27.69	1.05%
SULFAMETHOXAZOLE-TRIMETHOPRIM	SULFONAMIDES (SYSTEMIC)	2,206	$ 19,449.35	$ 8.82	1.03%
TRAZODONE HCL	ANTIDEPRESSANTS	2,142	$ 14,408.50	$ 6.73	1.00%
CEPHALEXIN	CEPHALOSPORINS	2,122	$ 25,459.14	$ 12.00	0.99%
LORATADINE	SECOND GENERATION ANTIHISTAMINES	2,092	$ 13,655.84	$ 6.53	0.98%
VENTOLIN HFA	BETA-ADRENERGIC AGONISTS	1,994	$ 77,383.66	$ 38.81	0.93%
DEXTROAMPHETAMINE-AMPHETAMINE	AMPHETAMINES	1,916	$ 320,741.69	$ 167.40	0.90%
LISINOPRIL	ANGIOTENSIN-CONVERTING ENZYME INHIBITORS	1,913	$ 12,178.20	$ 6.37	0.89%
CITALOPRAM HBR	ANTIDEPRESSANTS	1,870	$ 12,583.41	$ 6.73	0.87%
TOTAL TOP 25		78,994	$ 2,700,511.55	$ 34.19	36.90%

Total Rx Claims From 10/01/2011 - 12/31/2011	214,061

Top 10 Drugs
Based on Number of Claims

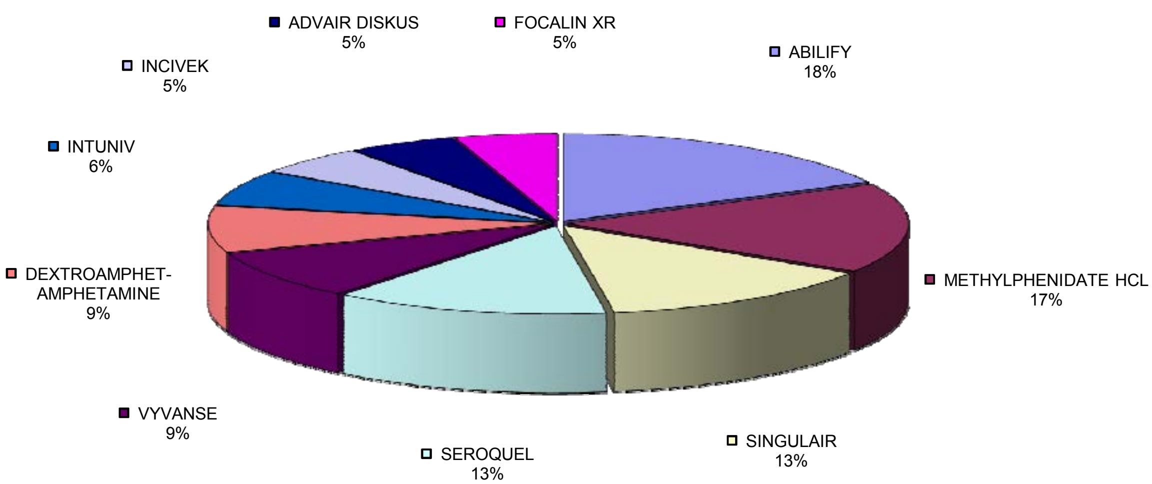


TOP 25 DRUGS BASED ON TOTAL CLAIMS COST FROM 10/01/2011 - 12/31/2011

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
ABILIFY	ANTIPSYCHOTIC AGENTS	1,422	$ 664,028.50	$ 466.97	0.66%
METHYLPHENIDATE HCL	ANOREX.,RESPIR.,CEREBRAL STIMULANTS,MISC	4,335	$ 623,316.26	$ 143.79	2.03%
SINGULAIR	LEUKOTRIENE MODIFIERS	3,728	$ 507,761.80	$ 136.20	1.74%
SEROQUEL	ANTIPSYCHOTIC AGENTS	1,526	$ 493,074.88	$ 323.12	0.71%
VYVANSE	AMPHETAMINES	2,429	$ 339,022.23	$ 139.57	1.13%
DEXTROAMPHET-AMPHETAMIN	AMPHETAMINES	1,916	$ 320,741.69	$ 167.40	0.90%
INTUNIV	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	1,594	$ 244,479.16	$ 153.37	0.74%
INCIVEK	HCV PROTEASE INHIBITORS	13	$ 200,758.89	$ 15,442.99	0.01%
ADVAIR DISKUS	CORTICOSTEROIDS (RESPIRATORY TRACT)	907	$ 193,725.68	$ 213.59	0.42%
FOCALIN XR	ANOREX.,RESPIR.,CEREBRAL STIMULANTS,MISC	1,120	$ 182,761.67	$ 163.18	0.52%
STRATTERA	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	995	$ 168,454.97	$ 169.30	0.46%
OLANZAPINE	ANTIPSYCHOTIC AGENTS	233	$ 158,710.37	$ 681.16	0.11%
ZYPREXA	ANTIPSYCHOTIC AGENTS	204	$ 148,176.64	$ 726.36	0.10%
CYMBALTA	ANTIDEPRESSANTS	813	$ 144,655.93	$ 177.93	0.38%
OXYCONTIN	OPIATE AGONISTS	447	$ 144,352.49	$ 322.94	0.21%
INVEGA SUSTENNA	ANTIPSYCHOTIC AGENTS	107	$ 131,724.06	$ 1,231.07	0.05%
NOVOLOG	INSULINS	595	$ 130,473.98	$ 219.28	0.28%
GENOTROPIN	PITUITARY	78	$ 128,272.01	$ 1,644.51	0.04%
GEODON	ANTIPSYCHOTIC AGENTS	291	$ 125,336.81	$ 430.71	0.14%
AZITHROMYCIN	MACROLIDES	7,050	$ 121,563.32	$ 17.24	3.29%
XOPENEX	BETA-ADRENERGIC AGONISTS	702	$ 120,330.93	$ 171.41	0.33%
FLOVENT HFA	CORTICOSTEROIDS (RESPIRATORY TRACT)	923	$ 119,503.35	$ 129.47	0.43%
LYRICA	ANTICONVULSANTS, MISCELLANEOUS	626	$ 111,237.06	$ 177.69	0.29%
BUDESONIDE	CORTICOSTEROIDS (RESPIRATORY TRACT)	454	$ 110,340.17	$ 243.04	0.21%
LEXAPRO	ANTIDEPRESSANTS	978	$ 108,865.04	$ 111.31	0.46%
TOTAL TOP 25		33,486	$ 5,741,667.89	$ 171.46	15.64%

Total Rx Claims From 10/01/2011 - 12/31/2011	214,061

Top 10 Drugs
Based on Total Claims Cost



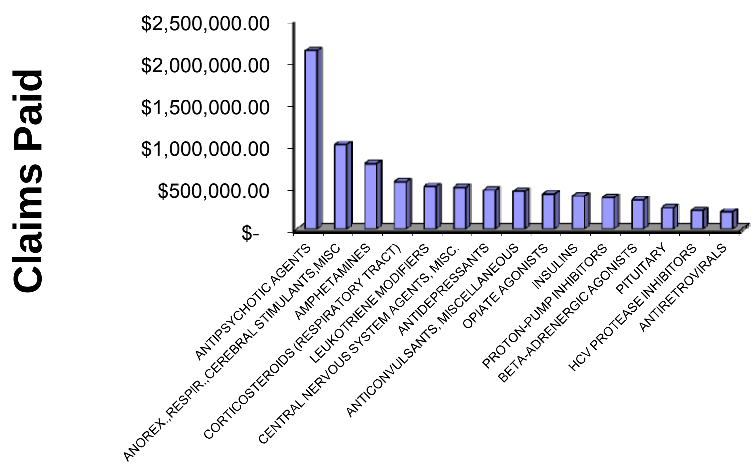
SOUTH DAKOTA MEDICAID
Cost Management Analysis

TOP 15 THERAPEUTIC CLASSES BY TOTAL COST OF CLAIMS FROM 10/01/2011 - 12/31/2011

AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
ANTIPSYCHOTIC AGENTS	7,000	$ 2,137,385.59	$ 305.34	3.27%
ANOREX.,RESPIR.,CEREBRAL STIMULANTS,MISC	6,644	$ 1,012,476.38	$ 152.39	3.10%
AMPHETAMINES	5,464	$ 783,188.28	$ 143.34	2.55%
CORTICOSTEROIDS (RESPIRATORY TRACT)	3,067	$ 565,883.77	$ 184.51	1.43%
LEUKOTRIENE MODIFIERS	3,736	$ 508,242.75	$ 136.04	1.75%
CENTRAL NERVOUS SYSTEM AGENTS, MISC.	2,651	$ 496,771.96	$ 187.39	1.24%
ANTIDEPRESSANTS	15,601	$ 466,340.54	$ 29.89	7.29%
ANTICONVULSANTS, MISCELLANEOUS	7,543	$ 452,013.02	$ 59.92	3.52%
OPIATE AGONISTS	14,161	$ 418,652.08	$ 29.56	6.62%
INSULINS	2,076	$ 394,159.26	$ 189.86	0.97%
PROTON-PUMP INHIBITORS	6,035	$ 377,317.21	$ 62.52	2.82%
BETA-ADRENERGIC AGONISTS	7,475	$ 350,957.47	$ 46.95	3.49%
PITUITARY	554	$ 255,032.40	$ 460.35	0.26%
HCV PROTEASE INHIBITORS	18	$ 223,205.34	$ 12,400.30	0.01%
ANTIRETROVIRALS	249	$ 207,513.77	$ 833.39	0.12%
TOTAL TOP 15	82,274	$ 8,649,139.82	$ 105.13	38.43%

Total Rx Claims From 10/01/2011 - 12/31/2011	214,061

Top 15 Therapeutic Classes
Based on Total Cost of Claims



ANTI-HISTAMINE PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving anti-histamines must use **Loratadine*** as first line.

- **Loratadine OTC and cetirizine may be prescribed WITHOUT prior authorization. Loratadine and cetirizine are covered by Medicaid when prescribed by a physician.**
- **Prior authorization is NOT required for patients < 13 years of age.**
- **Patients must use loratadine and cetirizine for a minimum of 14 days for the trial to be considered a failure. Patient preference does not constitute failure.**
- **Patients are encouraged to try and fail generic loratadine and cetirizine prior to receiving a leukotriene modifier or intranasal steroid to treat allergic rhinitis.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

REQUESTED DRUG (PLEASE CHECK)**:** ❑ Allegra ❑ Allegra-D ❑ Claritin Rx ❑ Clarinex ❑ Clarinex –D ❑ Claritin-D Rx ❑ Zyrtec ❑ Zyrtec-D ❑ Fexofenadine ❑ Xyzal	**Requested Dosage:** (must be completed) **Diagnosis for this request:**

Qualifications for coverage:

❑ Failed loratadine ❑ Failed cetirizine	Was trial for at least 14 days? ❑ YES ❑ NO	Dose: Frequency:

Adverse Reaction (attach FDA Medwatch form) to loratadine or cetirizine or contraindicated: (provide description below)

Physician Signature: Date:

Part IV: PHARMACY INFORMATION

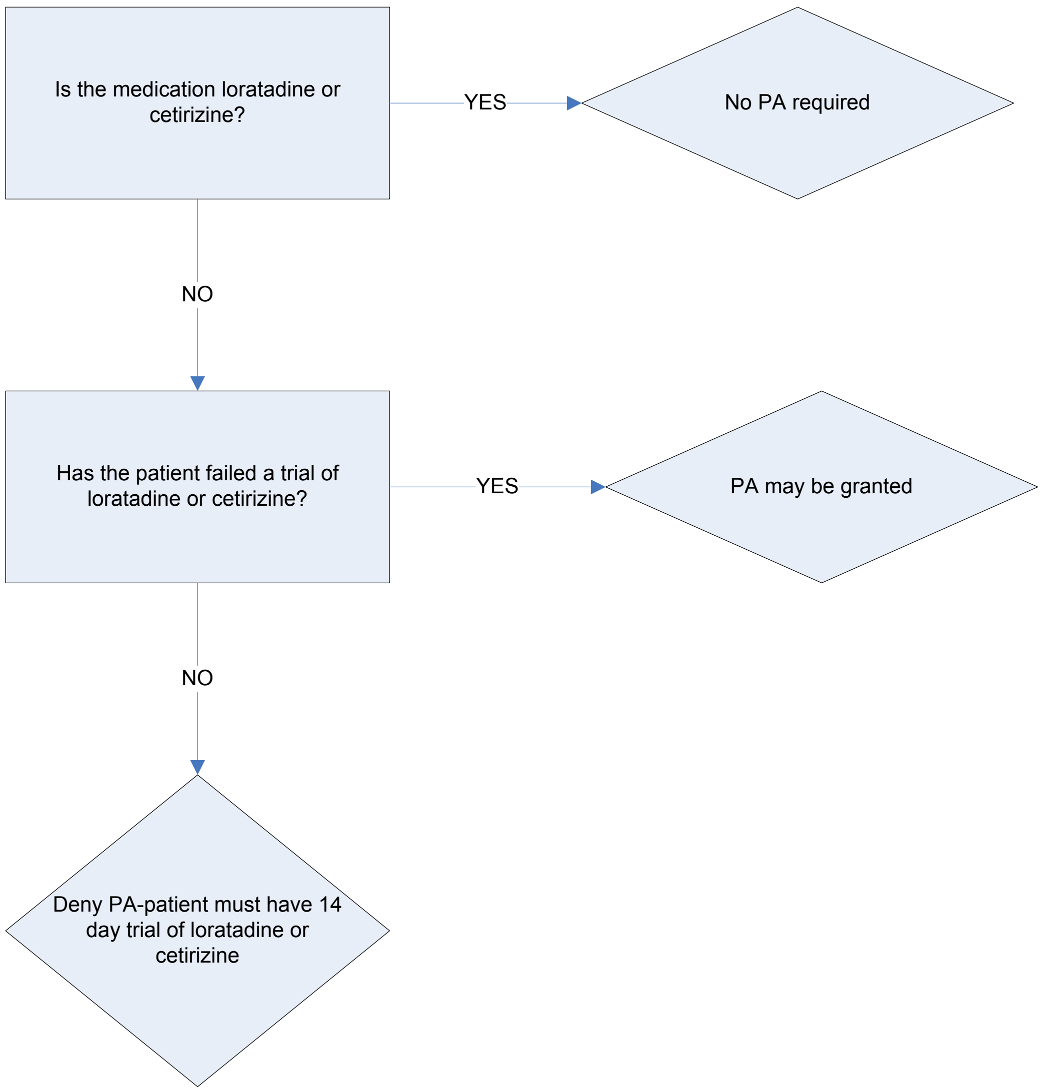
PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services

Antihistamine Prior Authorization Criteria



ARB PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving an ARB first try and fail one ACE Inhibitor. A PA may be given for one of the following reasons:

- **The patient has been stable on an ARB for greater than 60 days**
- **Patient has an additional diagnosis (such as COPD or RF) that precludes a trial with an ACE Inhibitor**
- **The provider has additional medical justification that supports first-line therapy with an ARB**

ARBs include: Atacand, Atacand/HCT, Avapro, Avalide, Benicar, Benicar/HCT, Cozaar, Diovan, Diovan/HCT, Edarbi, Hyzaar, Micardis, Micardis/HCT, Teveten, Teveten/HCT.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy)

RECIPIENT NAME:		RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /		
Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy)		
PHYSICIAN NAME:		PHYSICIAN MEDICAID ID NUMBER:
City:	FAX: ( )	Phone: ( )
Part III: TO BE COMPLETED BY PHYSICIAN		
REQUESTED DRUG:	**Requested Dosage:** (must be completed)	
	Diagnosis for this request:	

Qualifications for coverage:

Has patient been stable on requested ARB for more than 60 days? ❑ YES ❑ NO

Has patient tried and failed an ACE Inhibitor? ❑ YES ❑ NO

Does patient have a diagnosis of COPD or acute/chronic renal failure? ❑ YES ❑ NO

Medical Justification for use of an ARB without a trial of an ACEI:

Physician Signature: Date:

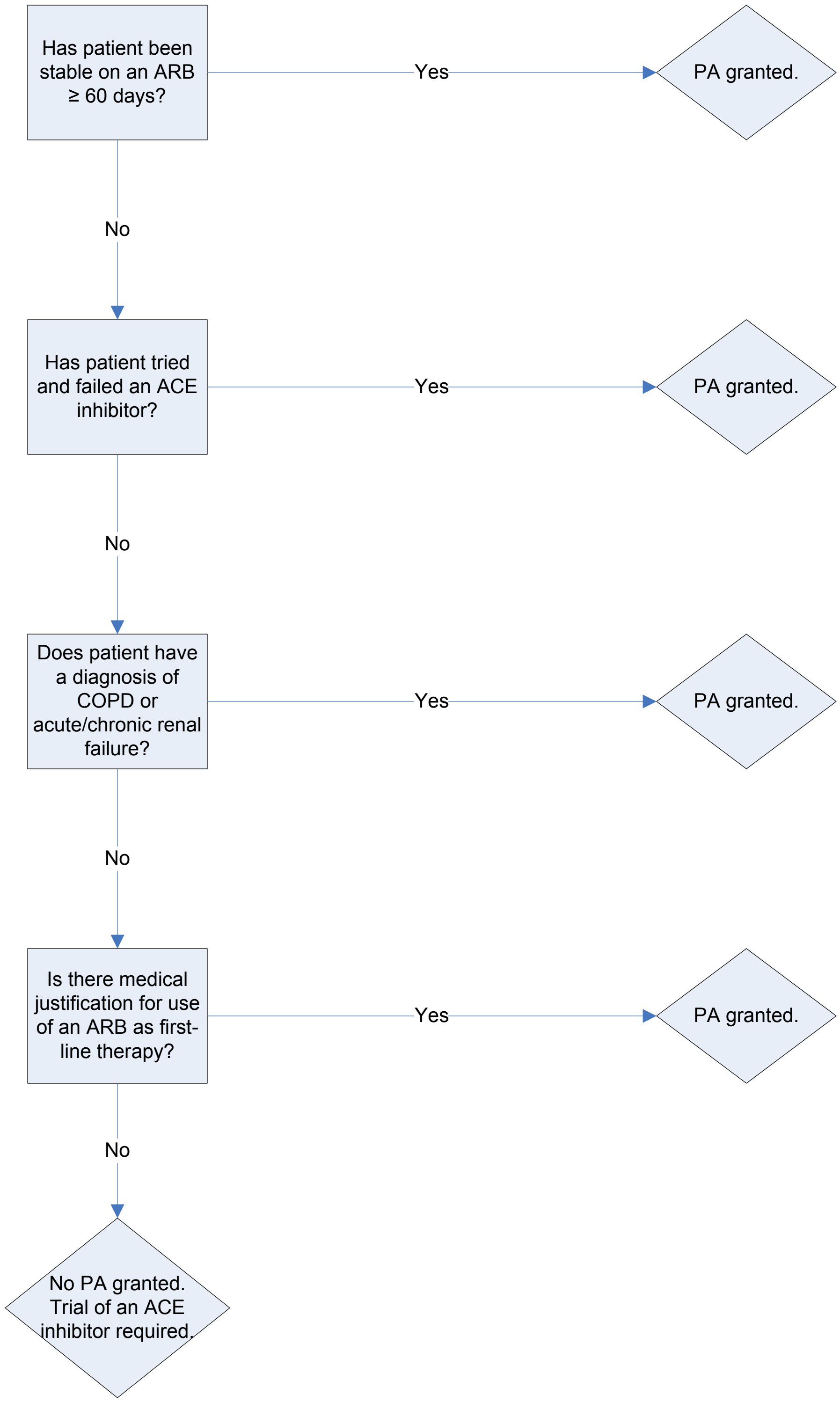
Part IV: TO BE COMPLETED BY PHARMACY

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
ARB Authorization Criteria Algorithm



AMBIEN CR PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients have a trial of zolpidem prior to receiving a PA for Ambien CR.

- **Patients must use generic zolpidem for a minimum of 14 days for the trial to be considered a failure.**
- **Previous usage of Ambien CR does not count as a trial.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
City:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Dosage: (must be completed) **Diagnosis for this request:**		
Qualifications for coverage:		
❑ Failed trial of zolpidem in the last 365 days	Was zolpidem trial for at least 14 days? ❑ YES ❑ NO	Zolpidem Dose:
		Zolpidem Frequency:
Adverse Reaction (attach FDA Medwatch form) or contraindication to zolpidem: (provide description below):		
Medical Justification for use of Ambien CR without trial of zolpidem:		
Physician Signature:		Date:

Part IV: PHARMACY INFORMATION

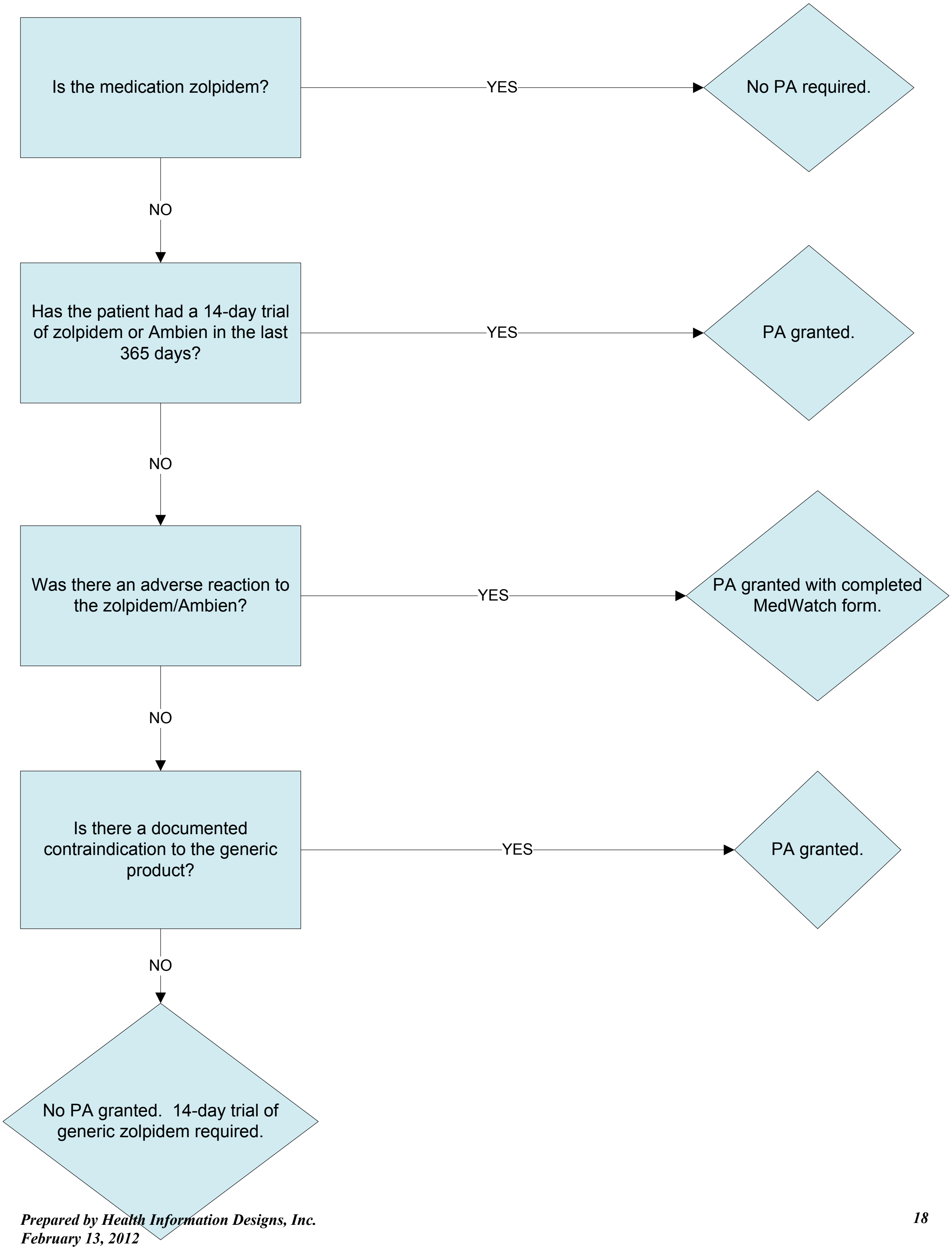
PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services

Ambien CR Criteria Algorithm



DISPENSE AS WRITTEN PRIOR AUTHORIZATION

SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to: **866-254-0761** **For questions regarding this Prior authorization, call** **866-705-5391**

SD Medicaid requires that patients receiving brand name medications (with a generic available) first try and fail the generic product. A PA may be given for one the following reasons:

- **The generic product was not effective**
- **There was an adverse reaction with the generic product**
- **The generic product is not available**

If a drug is on the South Dakota Narrow Therapeutic Index list, the drug is excluded from the PA requirement

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy)

RECIPIENT NAME:		RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /		

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy)

PHYSICIAN NAME:		PHYSICIAN MEDICAID ID NUMBER:
City:	FAX: ( )	Phone: ( )

Part III: TO BE COMPLETED BY PHYSICIAN

REQUESTED BRAND NAME DRUG:	**Requested Dosage:** (must be completed)
	Diagnosis for this request:

Qualifications for coverage:

Has treatment with the generic equivalent been attempted? ❑ YES ❑ NO

If yes, please indicate the reason for discontinuation below.

❑ Adverse reaction to the generic equivalent (FDA Medwatch form is required – form is available at www.fda.gov or www.hidsdmedicaid.com)

❑ Contraindication of generic equivalent (please provide medical justification in this space):

Physician Signature: Date:

Part IV: TO BE COMPLETED BY PHARMACY

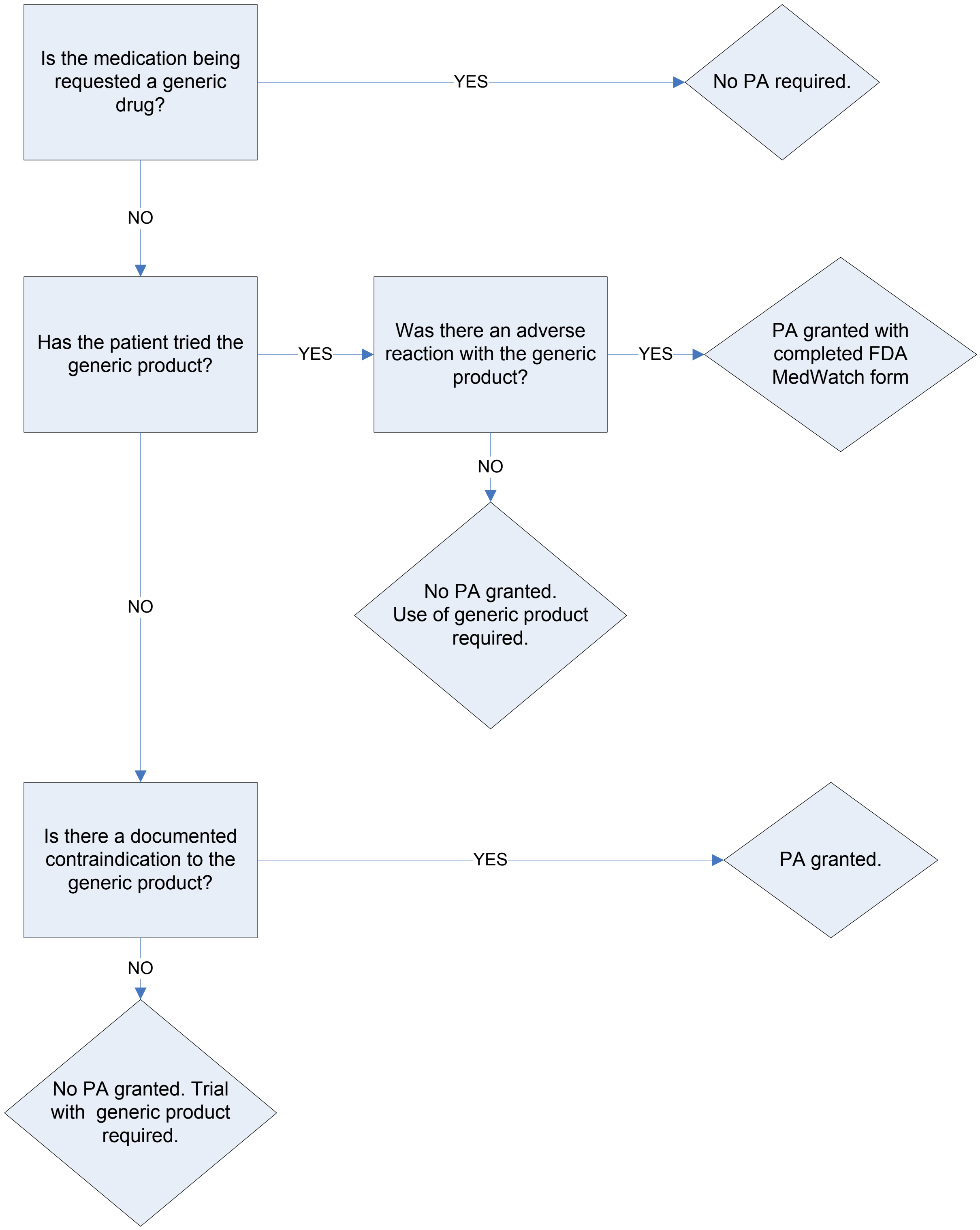
PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services

Dispense As Written Authorization Criteria Algorithm



PRIOR AUTHORIZATION REQUEST FORM
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

PEDIATRIC GROWTH HORMONE

Please fill out form completely (Note: if this is a renewal request, please include height chart and documentation regarding efficacy with the request)

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
RECIPIENT DOB:	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
Is prescribing physician board certified endocrinologist or nephrologist? ☐ YES ☐ NO	PHONE:	FAX:

Part III: TO BE COMPLETED BY PHYSICIAN:

REQUESTED DRUG:	**Requested Dosage:** (must be completed)
☐ INITIAL REQUEST ☐ RENEWAL REQUEST	**Diagnosis for this request:**

QUALIFICATIONS FOR COVERAGE:
(Renewal requests do NOT need to answer the questions below, please submit height chart and documentation of efficacy):

For Growth Hormone Deficiency (please submit either IGF-1 level OR provocative testing results):

IGF-1 Level:_________________

Provocative testing: Type______________________Results_______________________Date________________________

Has the patient been screened for intracranial malignancy or tumor? ☐ YES ☐ NO

For GHD AND Chronic Renal Insufficiency:
Is the patient's height value or growth velocity less than 2 standard deviations below the mean for age and/or Tanner Stage?
☐ YES ☐ NO

For Idiopathic Short Stature and SGA:
Please indicate patients height or include chart documentation:

Please indicate patient's predicted height:

For All Patients:
Does the patient have any of the following contraindications? Check all that apply.

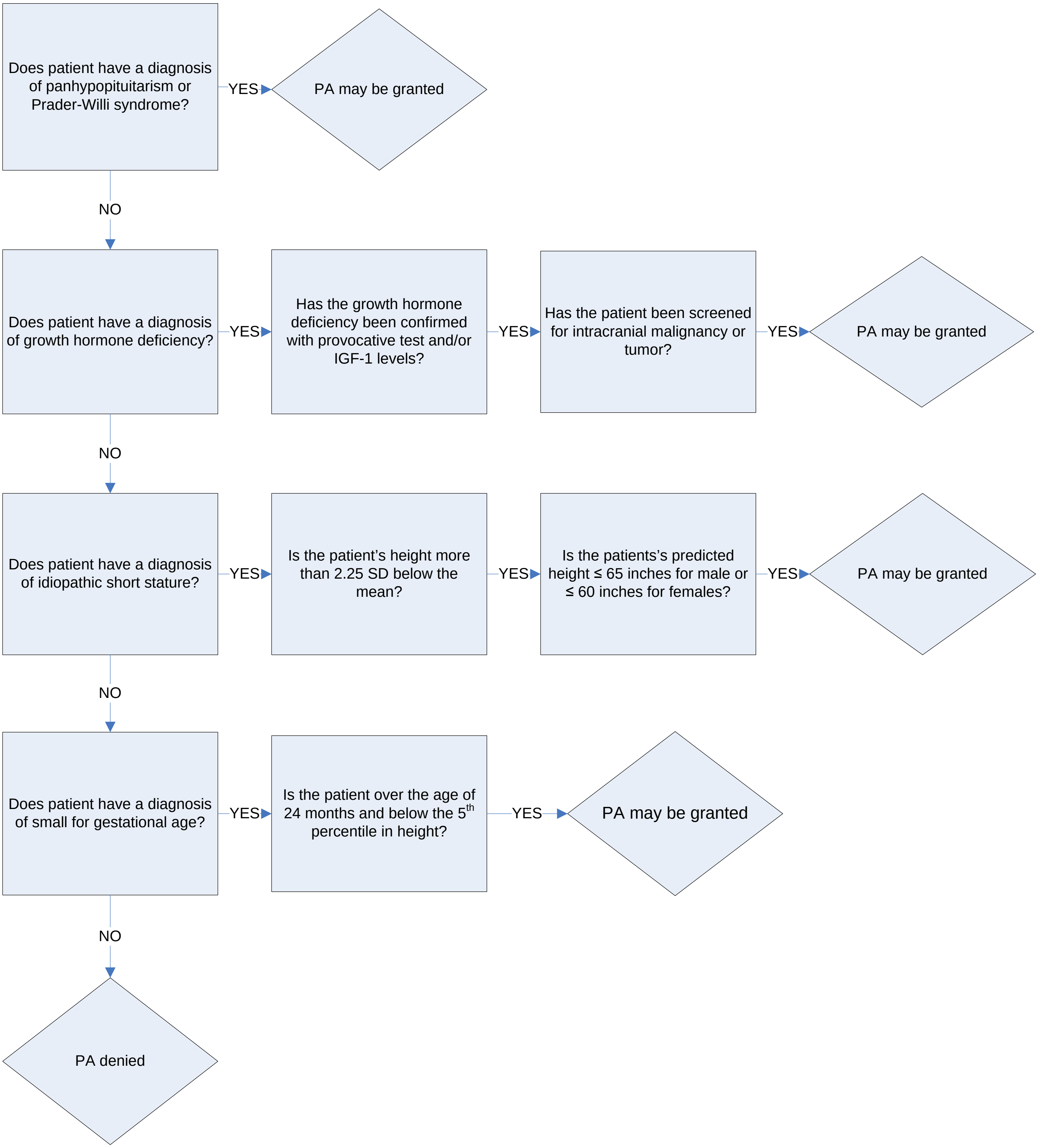
☐ Benign intracranial hypertension ☐ Closed epiphyses ☐ NONE

Physician signature:	Date:

Part IV: PHARMACY INFORMATION

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

South Dakota Department of Social Services
Pediatric Growth Hormone Criteria



HEAD LICE MEDICATION PRIOR AUTHORIZATION

SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a prescription for lindane or malathion must use Rid® or Nix® first line.

- **Rid or Nix may be prescribed WITHOUT a prior authorization**
- **For a trial to be considered a failure, patients must use Rid or Nix as directed, including retreatment within 7-10 days after the first treatment.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:			PHYSICIAN PROVIDER NUMBER:
City:	State:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: (must be completed)	**Diagnosis for this request:**
Qualifications for coverage:	
❑ Failed trial of Rid or Nix in the last 30 days.	Did trial include retreatment within 7-10 days after the first treatment? ❑ YES ❑ NO
Adverse Reaction (attach FDA MedWatch form) or contraindication: (provide description below):	
Medical Justification for use of lindane or malathion without trial of Nix:	
Physician Signature:	Date:

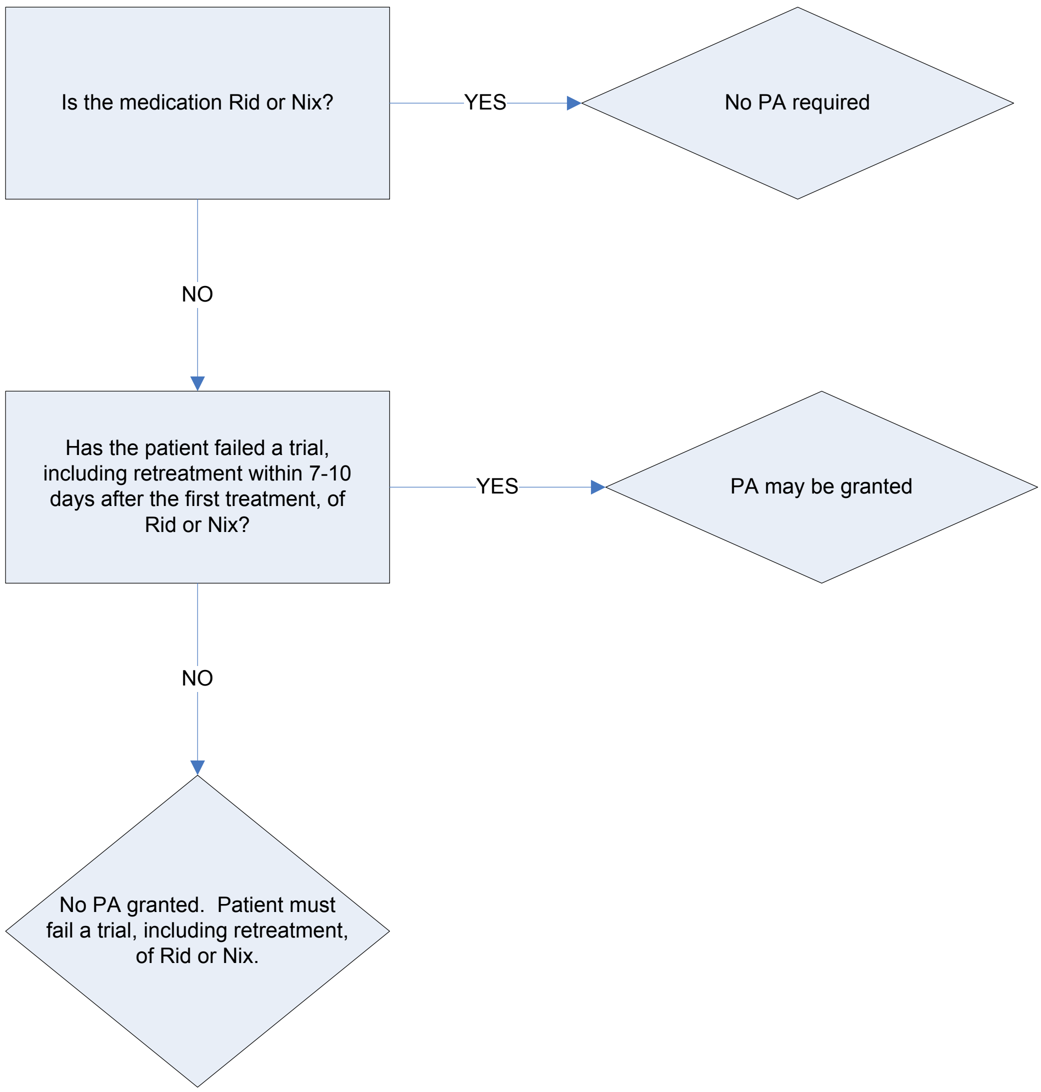
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

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



VUSION PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a prescription for Vusion must use nystatin or OTC miconazole first line.

- **Nystatin or miconazole OTC may be prescribed WITHOUT a prior authorization**
- **Patients must use nystatin or OTC miconazole for a minimum of 14 days for the trial to be considered a failure.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:			PHYSICIAN PROVIDER NUMBER:
City:	State:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: (must be completed)	**Diagnosis for this request:**
Qualifications for coverage:	
❑ Failed trial of nystatin or OTC miconazole in the last 30 days	Was trial for at least 14 days? ❑ YES ❑ NO
Adverse Reaction (attach FDA Medwatch form) or contraindication: (provide description below):	
Medical Justification for use of Vusion without trial of miconazole or nystatin:	
Physician Signature:	Date:

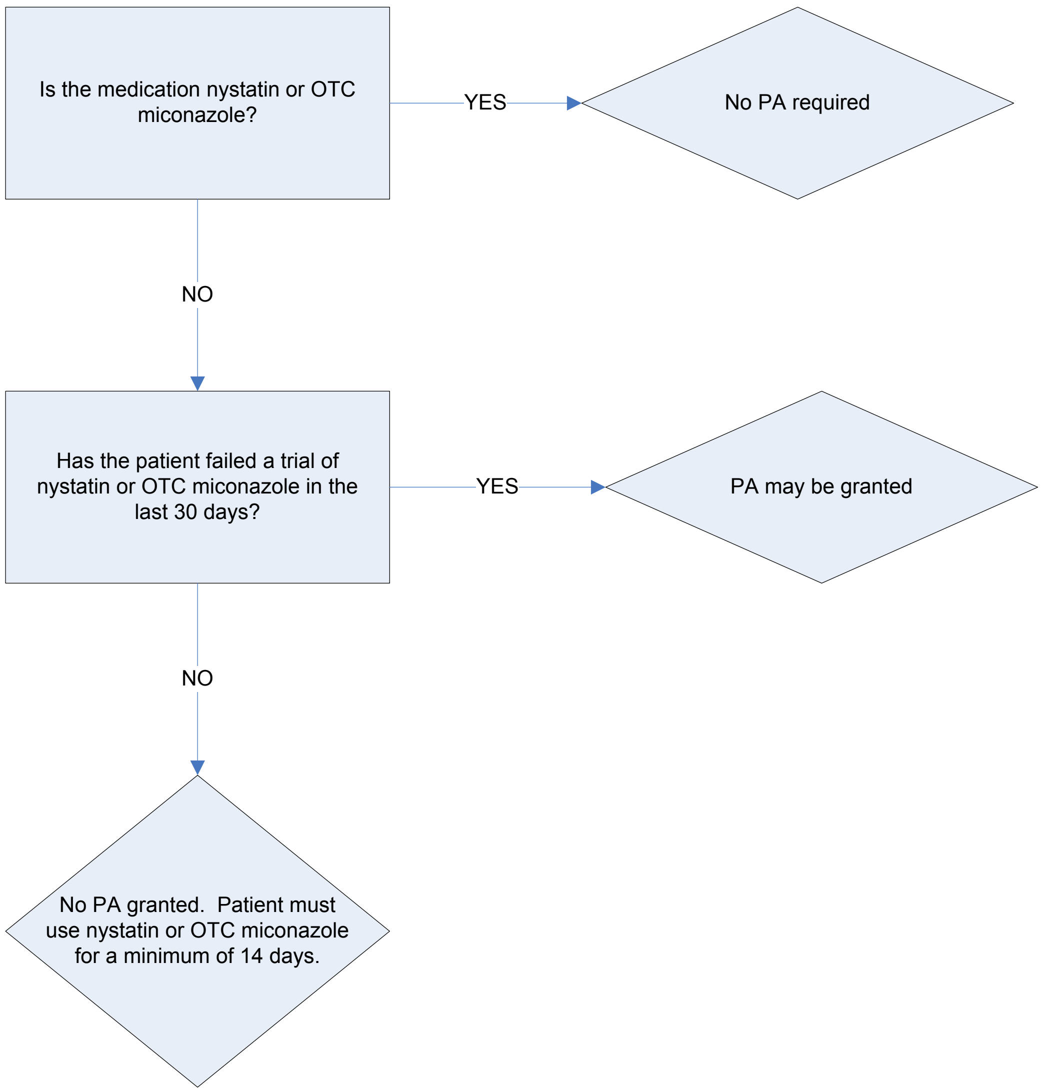
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Vusion Prior Authorization Criteria



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: End Date:	Dose: Frequency:

Adverse Reaction (attach FDA MedWatch form) or contraindication to inactive ingredients in cyclobenzaprine: (provide description below):

Medical Justification for use of Amrix or Fexmid without trial of cyclobenzaprine:

Physician Signature: Date:

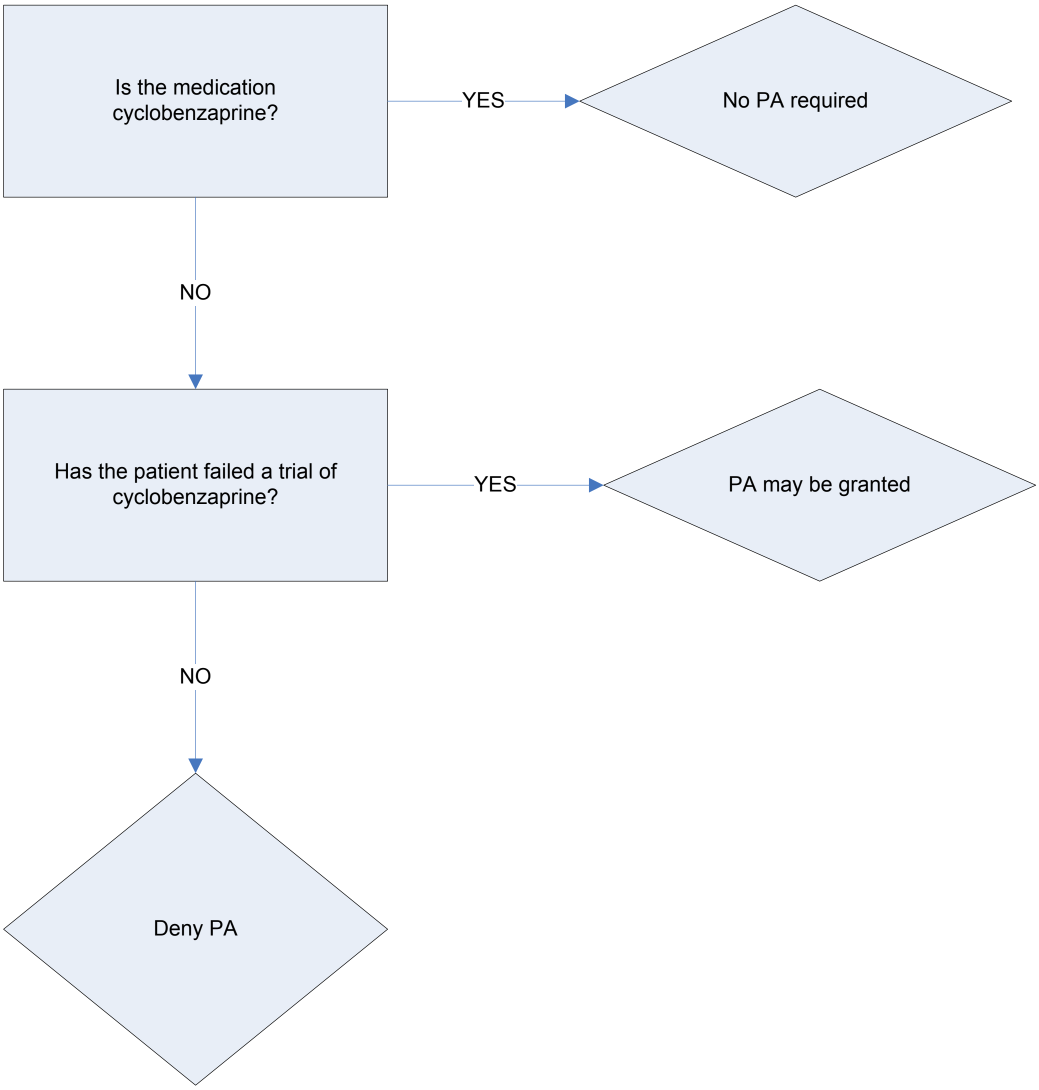
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

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



TARGETED IMMUNE MODULATORS PRIOR AUTHORIZATION

SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to: **866-254-0761** **For questions regarding this Prior authorization, call** **866-705-5391**

SD Medicaid requires that patients receiving a new prescription for Orencia, Humira, Enbrel, Amevive, Kineret, Cimzia, Remicade, and Simponi must submit a prior authorization form.

- **Prior authorization will be granted if the requested product has been approved by the FDA for the indication listed.**
- **Physician administered medications do not require a prior authorization**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage:	**FDA approved indication for this request:**
□ **Orencia** ______________________________	□ **Adult Rheumatoid Arthritis**
□ **Amevive** ______________________________	□ **Juvenile Idiopathic Arthritis**
□ **Enbrel** ______________________________	□ **Plaque Psoriasis**
□ **Kineret** ______________________________	□ **Ankylosing Spondylitis**
□ **Humira** ______________________________	□ **Psoriatic Arthritis**
□ **Cimzia** ______________________________	□ **Crohn's Disease**
□ **Remicade** ______________________________	□ **Ulcerative Colitis**
□ **Simponi** ______________________________	
PHYSICIAN SIGNATURE:	DATE:

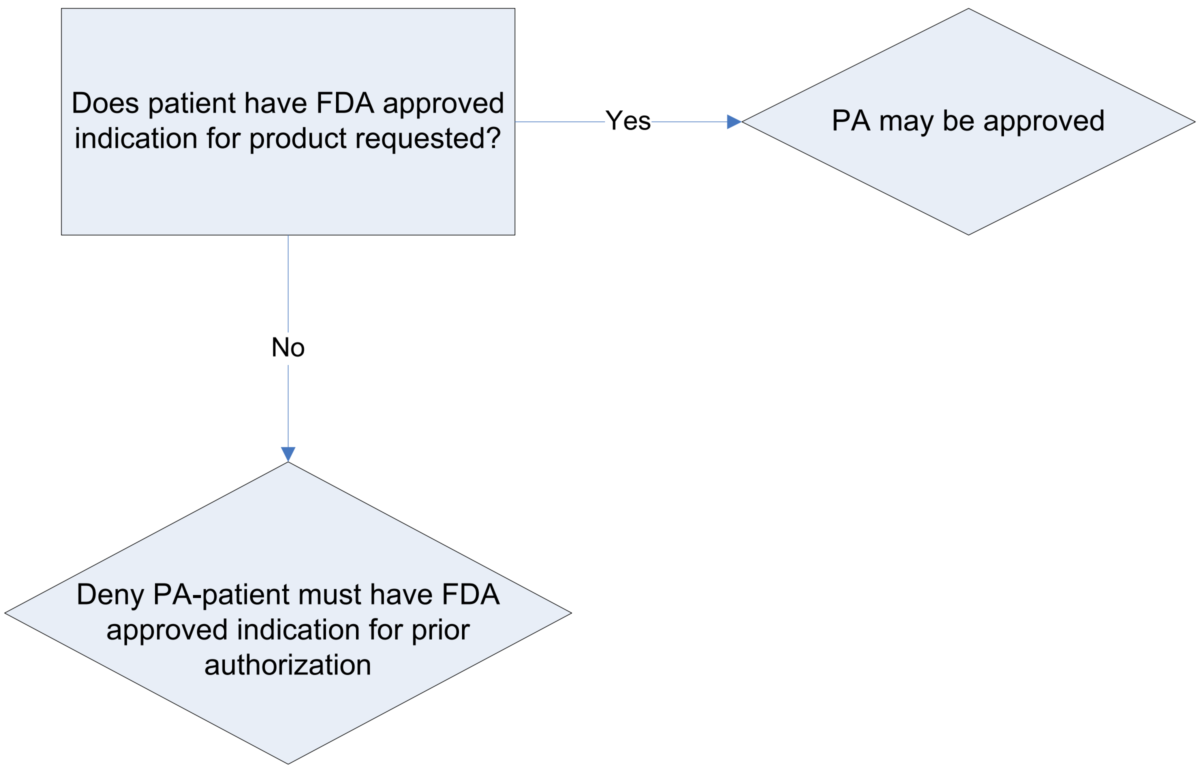
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Targeted Immune Modulators Authorization Algorithm



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.

- **Allopurinol does not require a prior authorization.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage:	Diagnosis for this request:
□ Failed Allopurinol Therapy Dose Frequency Start Date End Date	
□ Renal or Hepatic Impairment	□ Other (please explain) ______________________________
PHYSICIAN SIGNATURE:	DATE:

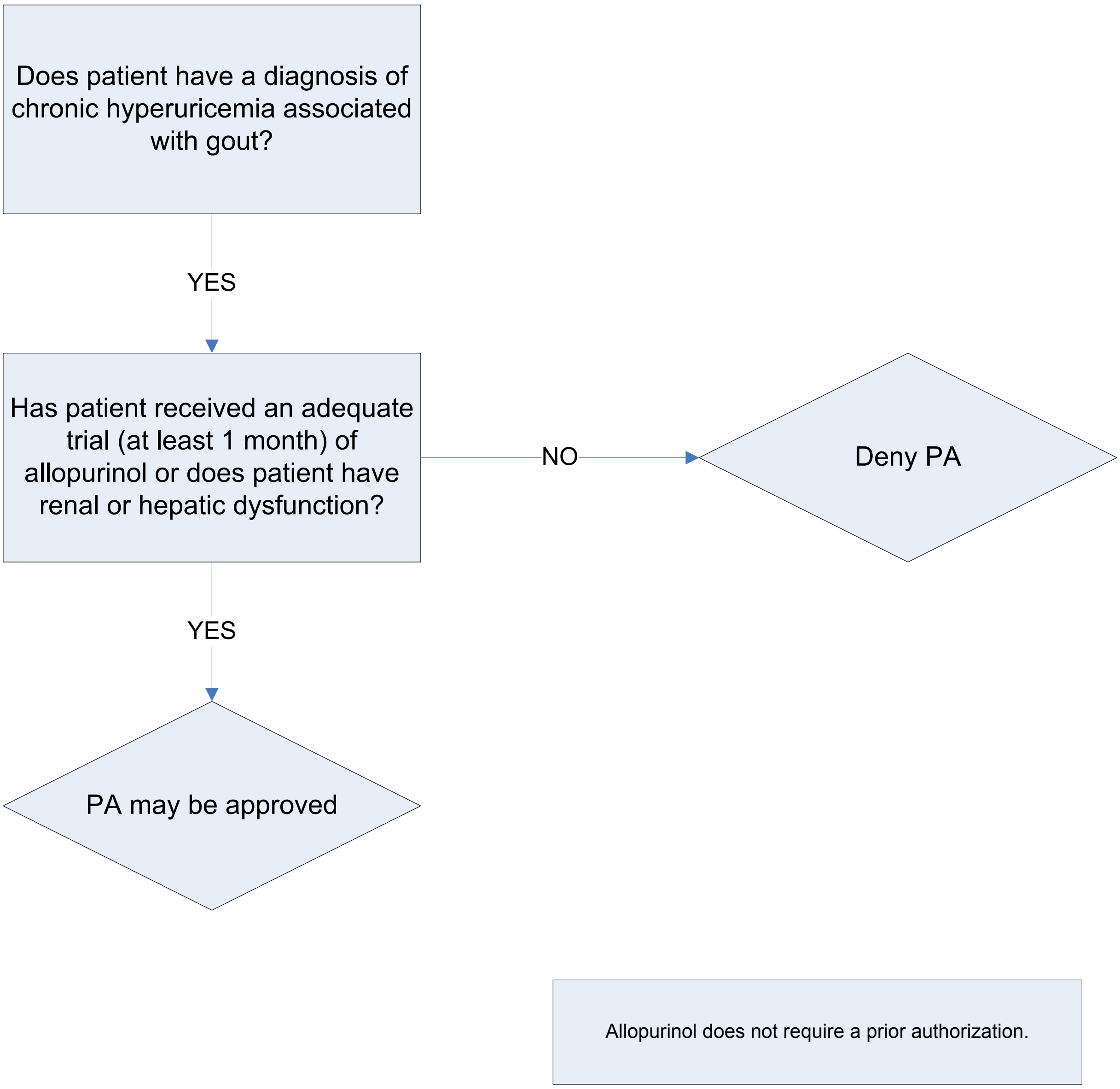
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Uloric Prior Authorization Algorithm



NUVIGIL and PROVIGIL
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Nuvigil or Provigil must submit a prior authorization form.

- **Prior authorization will be granted if the requested product has been approved by the FDA for the indication listed.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage:	**FDA approved indication for this request:**
□ **Nuvigil** ________________________ □ **Provigil**________________________	□ **Narcolepsy** □ **Excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome** □ **Shift work sleep disorder**
PHYSICIAN SIGNATURE:	DATE:

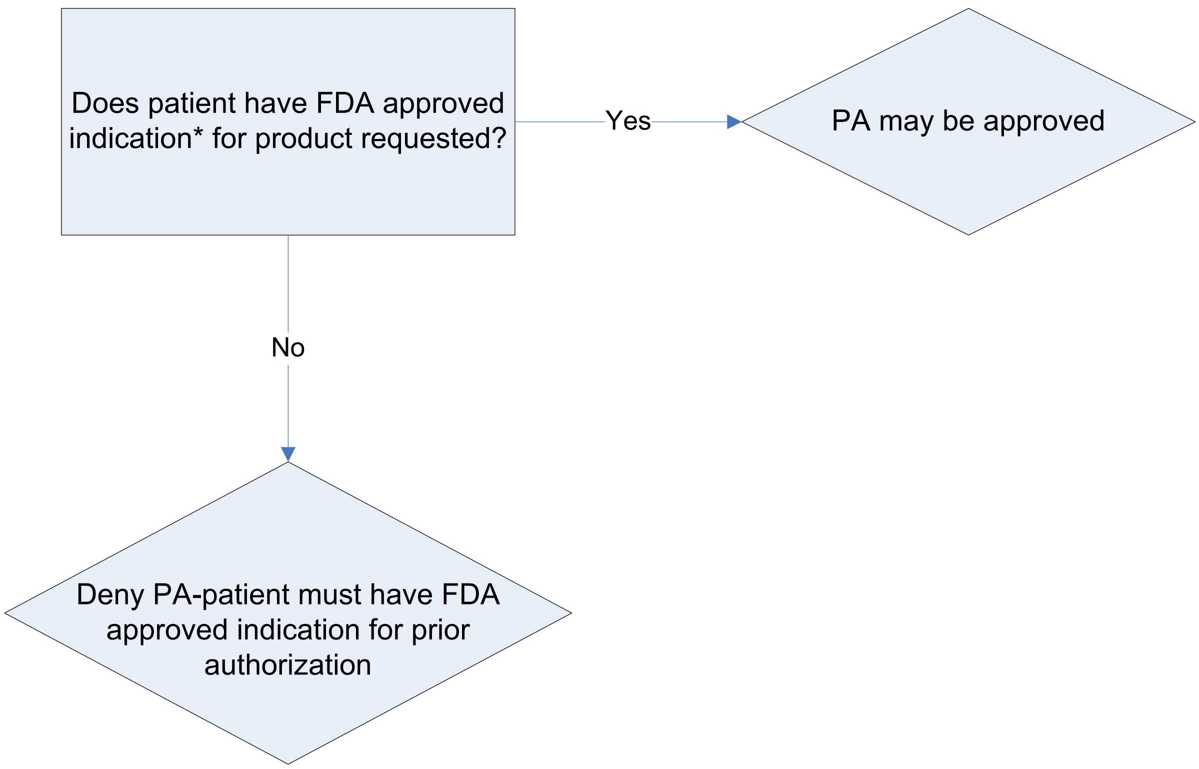
Part IV: PHARMACY INFORMATION

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)	

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



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

CALOMIST/NASCOBAL
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to: **866-254-0761** **For questions regarding this Prior authorization, call** **866-705-5391**

SD Medicaid requires that patients receiving a new prescription for CaloMist or Nascobal must try injectable B-12 as first line therapy.

- **Injectable B-12 does not require a prior authorization.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage:				Diagnosis for this request:
□ Failed Therapy	Dose	Frequency	Start Date	End Date
□ Medical Justification for use of CaloMist or Nascobal without a trial of injectable B-12:				
PHYSICIAN SIGNATURE:				DATE:

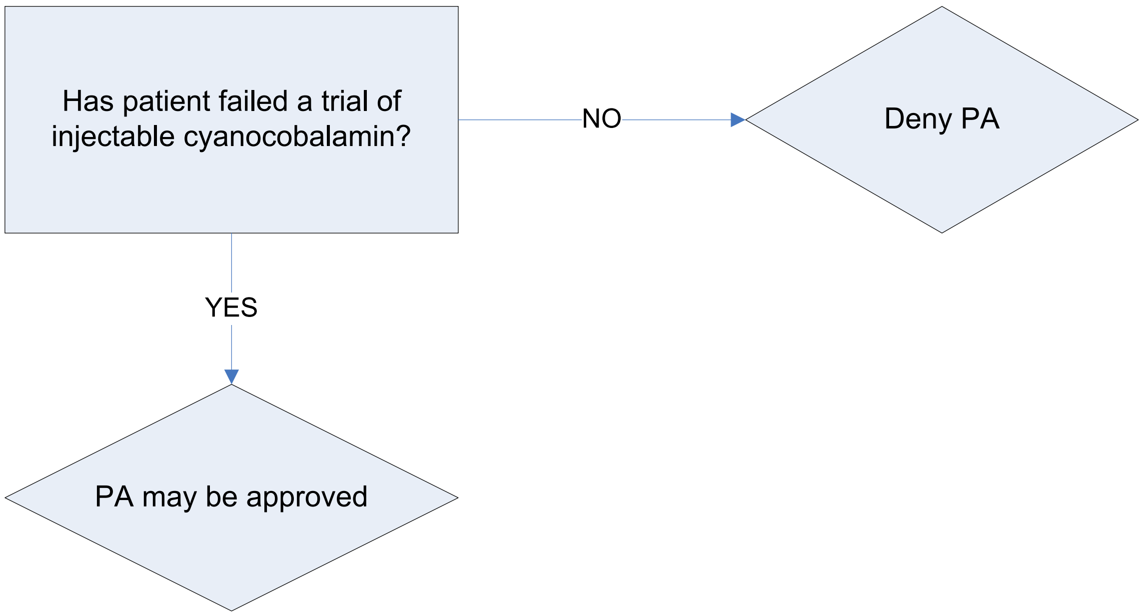
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

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



DESOXYN PA FORM
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

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

- **Patient must be over 6 years of age.**
- **Diagnosis of Attention Deficit Disorder with Hyperactivity. (Desoxyn is not covered for the treatment of obesity)**
- **Four documented trials of the following options: a long-acting amphetamine salts product; a long-acting methylphenidate product; a long-acting product with a short-acting product; guanfacine; and atomoxetine.**
- **Trials within the last 90 days**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy)

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy)

PHYSICIAN NAME:	PHYSICIAN MEDICAID ID NUMBER:	
City:	FAX: ( )	Phone: ( )

Part III: TO BE COMPLETED BY PHYSICIAN

REQUESTED DRUG:	**Requested Dosage:** (must be completed)
	Diagnosis for this request:

Qualifications for coverage:

	Drug Name/s	Start Date	End Date	Dose	Frequency
□ long-acting amphetamine salts					
□ long-acting methylphenidate					
□ long-acting product with a short-acting product					
□ guanfacine					
□ atomoxetine					

Physician Signature:	Date:

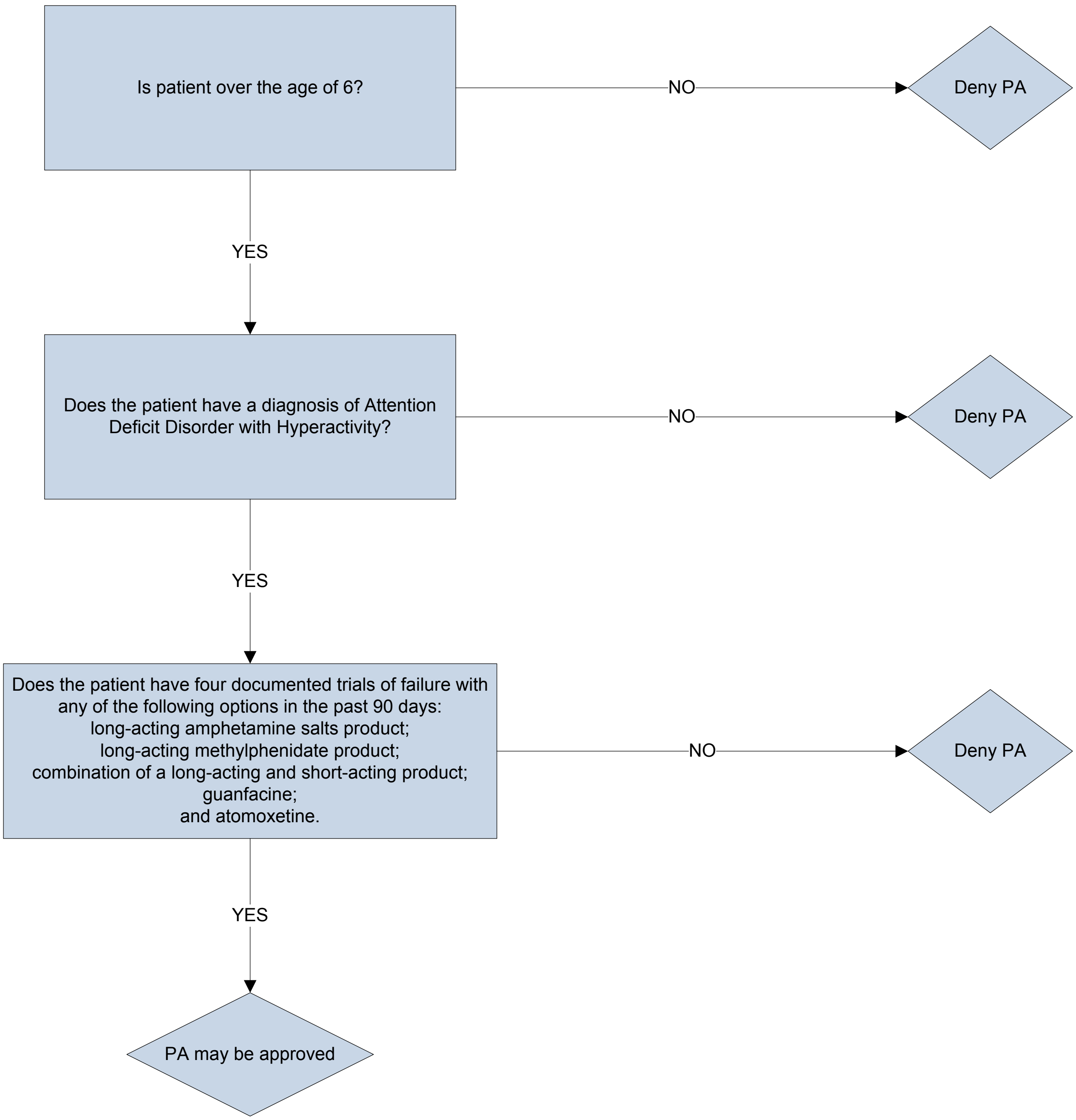
Part IV: TO BE COMPLETED BY PHARMACY

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Desoxyn Prior Authorization Criteria



ANTIDEPRESSANT PRIOR AUTHORIZATION FORM

SD DEPARTMENT OF SOCIAL SERVICES MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for a second tier antidepressant must fail a first tier agent.

- Tricyclics, trazodone, bupropion, citalopram, fluoxetine, mirtazapine, immediate release paroxetine, sertraline and venlafaxine do not require a prior authorization.
- Patients currently stabilized on a second generation antidepressant will not be asked to change medication.
- Escitalopram will not require a prior authorization for recipients under the age of 18.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
City:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: (must be completed) **Diagnosis for this request:**
Qualifications for coverage:
☐ One failed trial with an antidepressant from tier one. 1. List failed medication
Adverse Reaction (attach FDA MedWatch form) or contraindication: (provide description below):
Medical Justification for use of a tier two agent without trial of a tier one agent:
Physician Signature: Date:

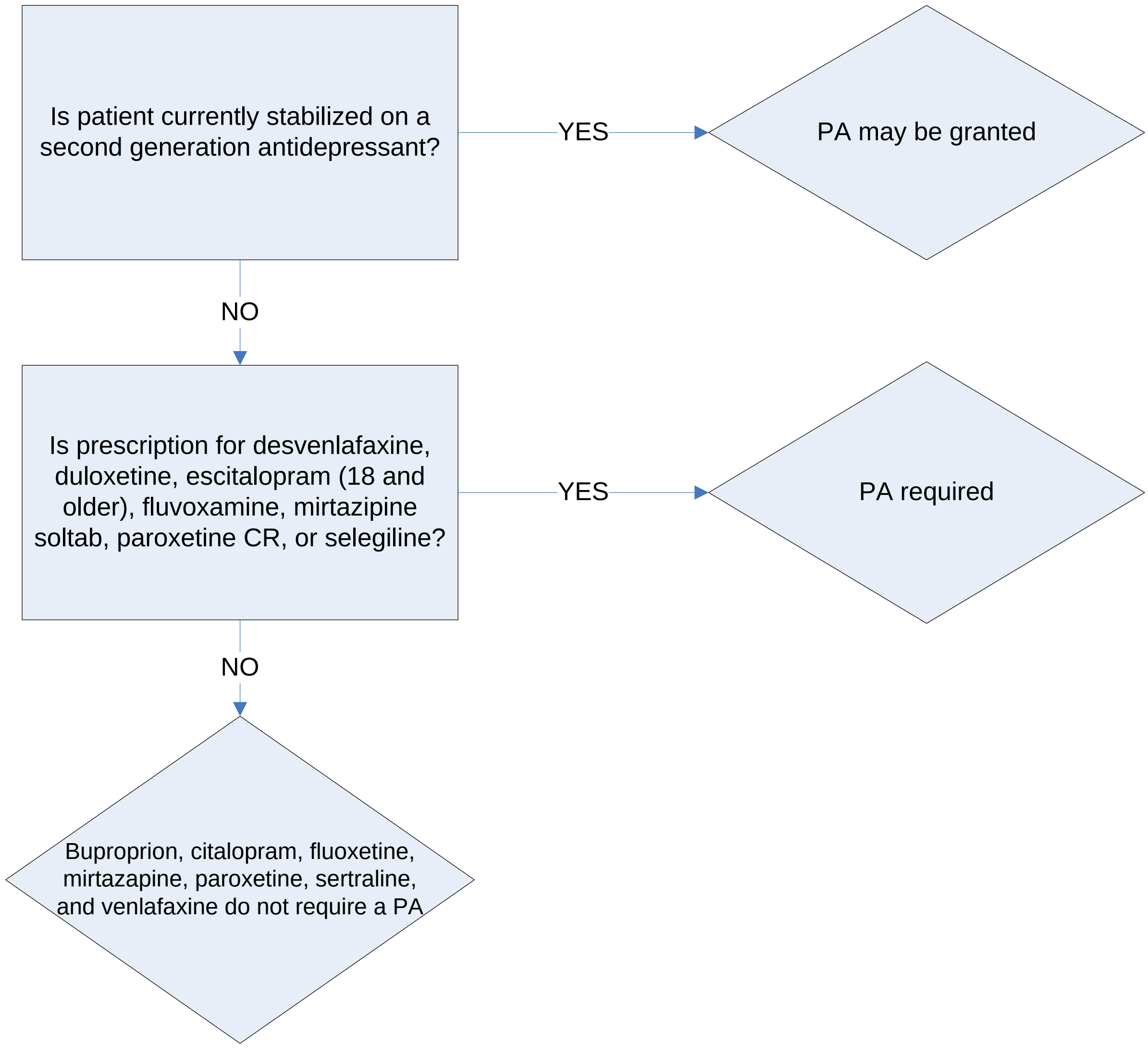
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Antidepressant Authorization Criteria



METOZOLV ODT PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

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

- **Patient must try metoclopramide.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN MEDICAID PROVIDER NUMBER:
PHYSICIAN ADDRESS:		
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug: (must be completed) **Diagnosis for this request:**			
Qualifications for coverage:			
❑ Failed metoclopramide therapy	Start Date:	End Date:	Dose:
Physician Signature:		Date:	

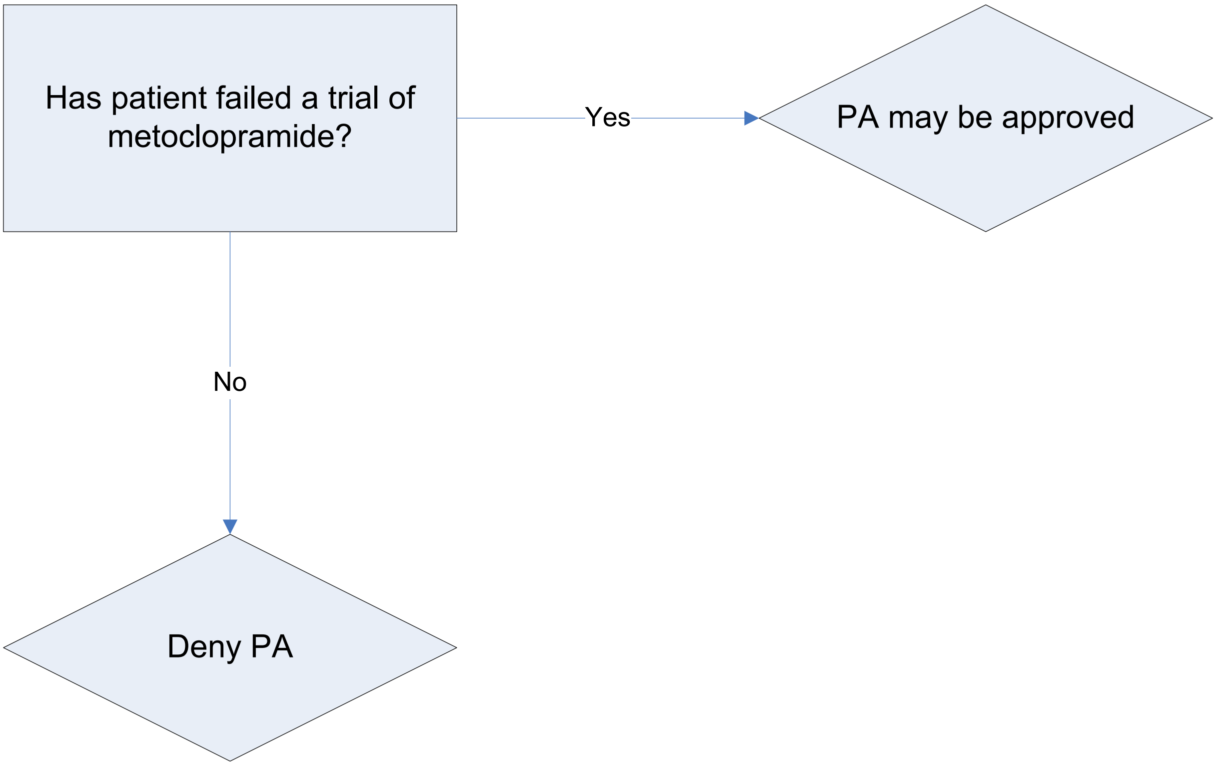
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Metozolv Prior Authorization Criteria



BRAND-NAME NARCOTICS PA FORM
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for a brand-name narcotic must meet the following criteria:

- **Documented failure of a 30-day trial of a generic narcotic at a dose equivalent to the brand-name narcotic being prescribed.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN MEDICAID PROVIDER NUMBER:
PHYSICIAN ADDRESS:		
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug: (must be completed)

☐ EMBEDA ☐ OPANA ☐ KADIAN ☐ AVINZA ☐ EXALGO ☐ FENTORA

☐ BUTRANS ☐ ABSTRAL ☐ COMBUNOX ☐ ONSOLIS ☐ MAGNACET

Qualifications for coverage:

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

Physician Signature:	Date:

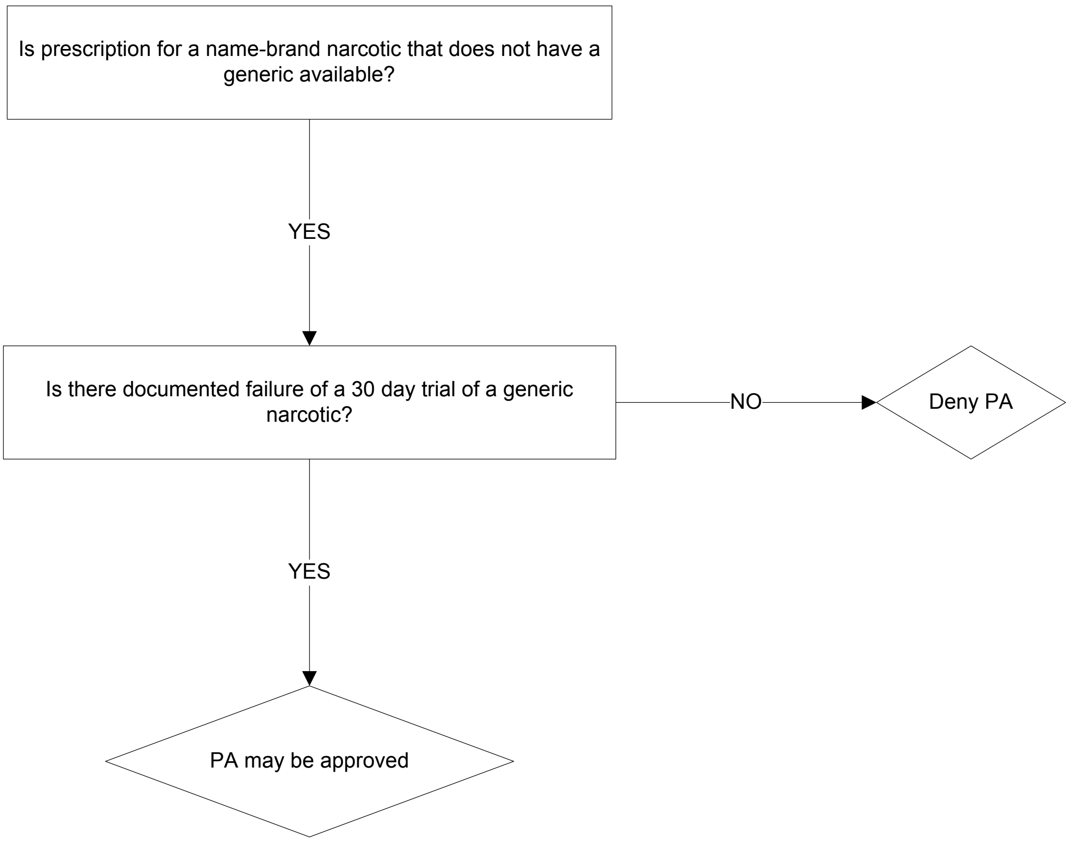
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

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



ORAVIG
PRIOR AUTHORIZATION

SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Oravig must first try clotrimazole troches, fluconazole tablets or nystatin suspension.

- **Clotrimazole troches, fluconazole tablets, and nystatin suspension do not require PA.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Oravig ________________________	Diagnosis for this request:
□ Medication failed and dose ____	**Start Date:** **End Date:**
PHYSICIAN SIGNATURE:	DATE:

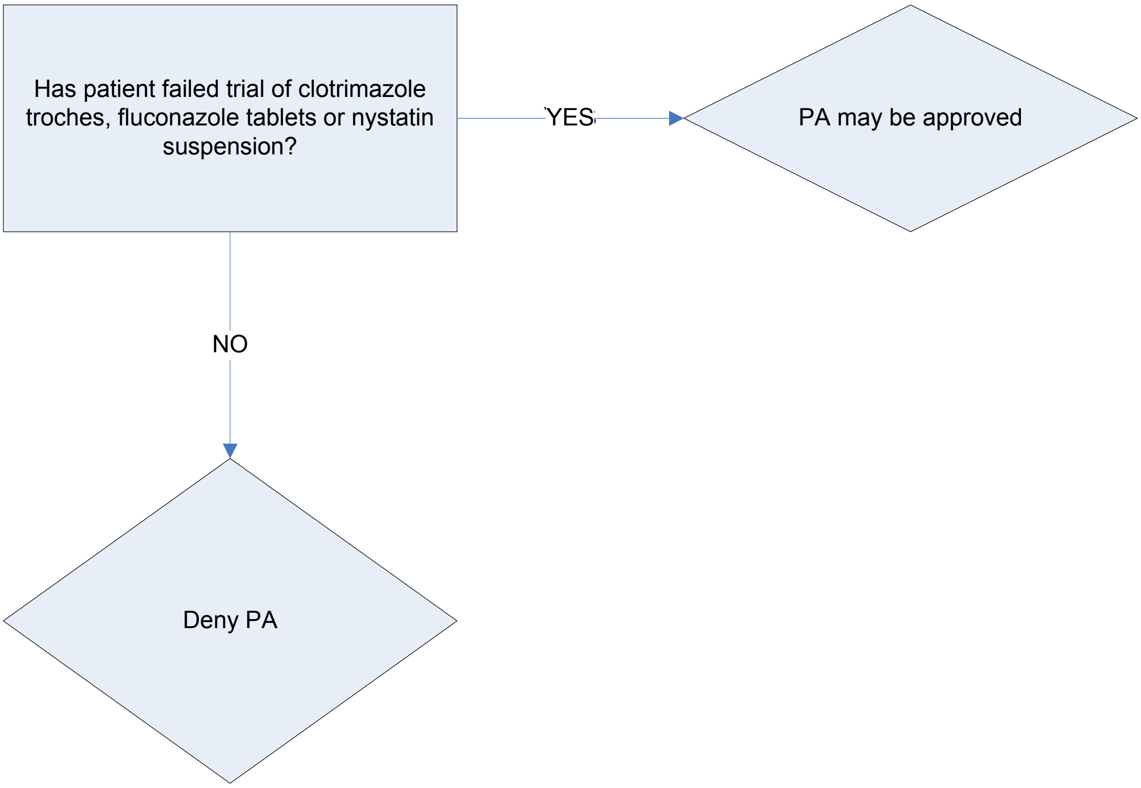
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Oravig Prior Authorization Algorithm



Serotonin (5-HT_1) Receptor Agonists
TRIPTAN PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to: **866-254-0761** **For questions regarding this Prior authorization, call** **866-705-5391**

SD Medicaid requires that patients receiving a new prescription for Amerge, Axert, Frova, Maxalt, Relpax, Treximet or Zomig must try Imitrex (sumatriptan) as first line therapy.

- **Imitrex (sumatriptan) does not require a PA.**
- **Injectables are not subject to a prior authorization at this time**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH:

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage:	Diagnosis for this request:
□ Amerge □ Relpax □ Axert □ Treximet □ Frova □ Zomig □ Maxalt	
□ Failed sumatriptan therapy (dose and frequency) ____________________________________	**Start Date:** **End Date:**
PHYSICIAN SIGNATURE:	DATE:

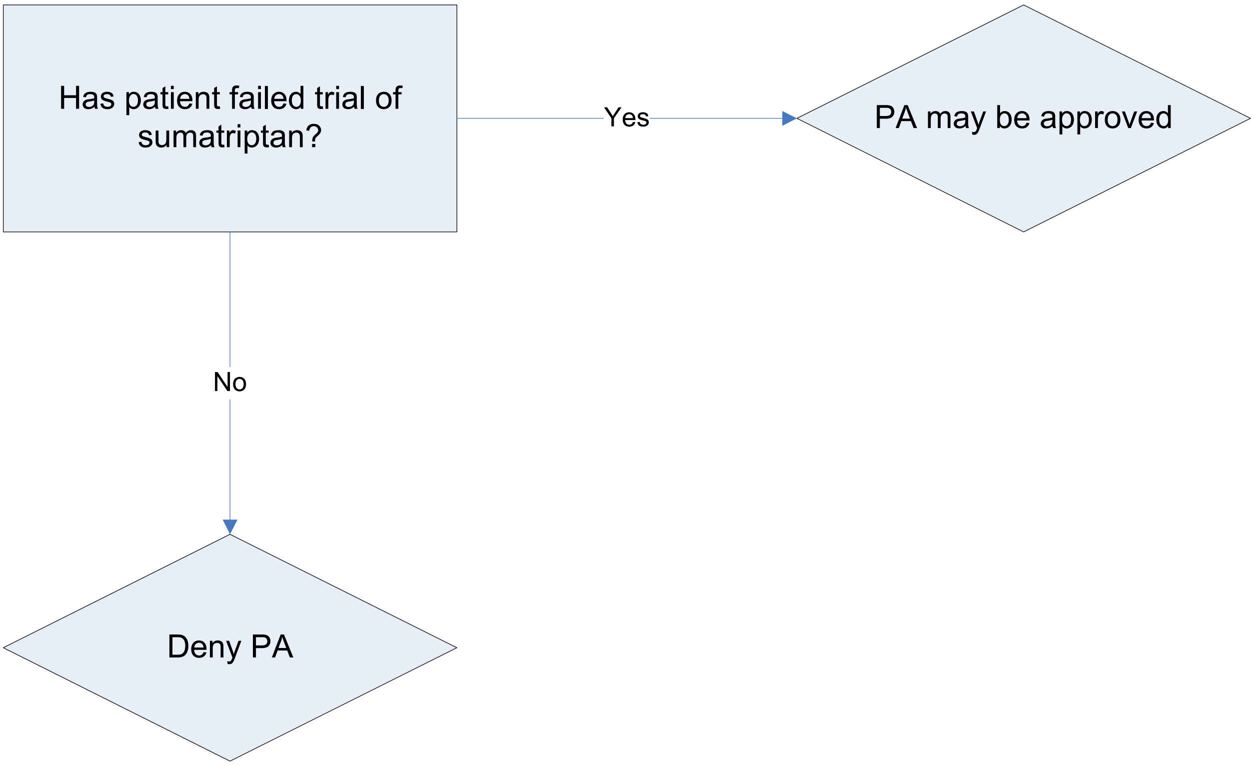
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

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



EXTAVIA
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to: **866-254-0761** **For questions regarding this Prior authorization, call** **866-705-5391**

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

- **Patient must have a confirmed diagnosis of relapsing remitting multiple sclerosis.**
- **Patient must have a neurologist involved in therapy.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER	NEUROLOGIST INVOLVED IN THERAPY:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Extavia	Diagnosis for this request:
Medication failed □ Betaseron	**Start Date:** **End Date:**
Please provide clinical rationale as to why Extavia should be used given Betaseron failure or intolerance. Please note: Betaseron and Extavia are both Interferon β-1b.	
PHYSICIAN SIGNATURE:	DATE:

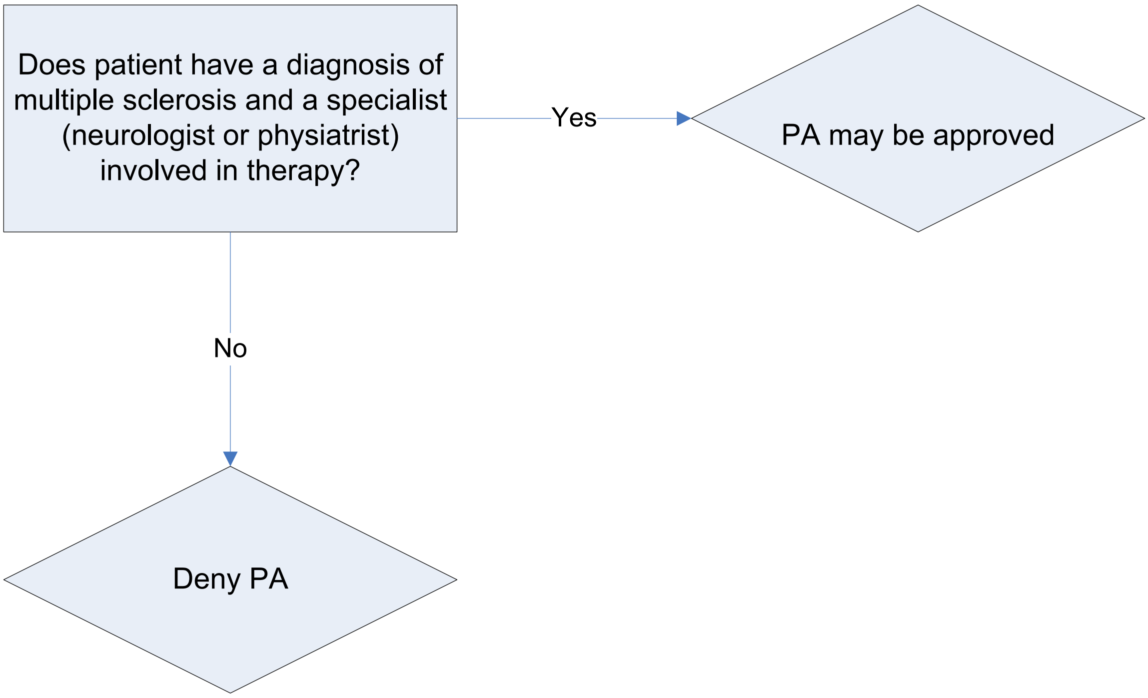
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Extavia Prior Authorization Algorithm



NOVANTRONE
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

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

- **Patient must have one of the following confirmed diagnoses: secondary progressive multiple sclerosis, progressive relapsing multiple sclerosis, or worsening relapsing-remitting multiple sclerosis.**
- **Patient must have a neurologist involved in therapy.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	NEUROLOGIST INVOLVED IN THERAPY:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Novantrone	Diagnosis for this request:
PHYSICIAN SIGNATURE:	DATE:

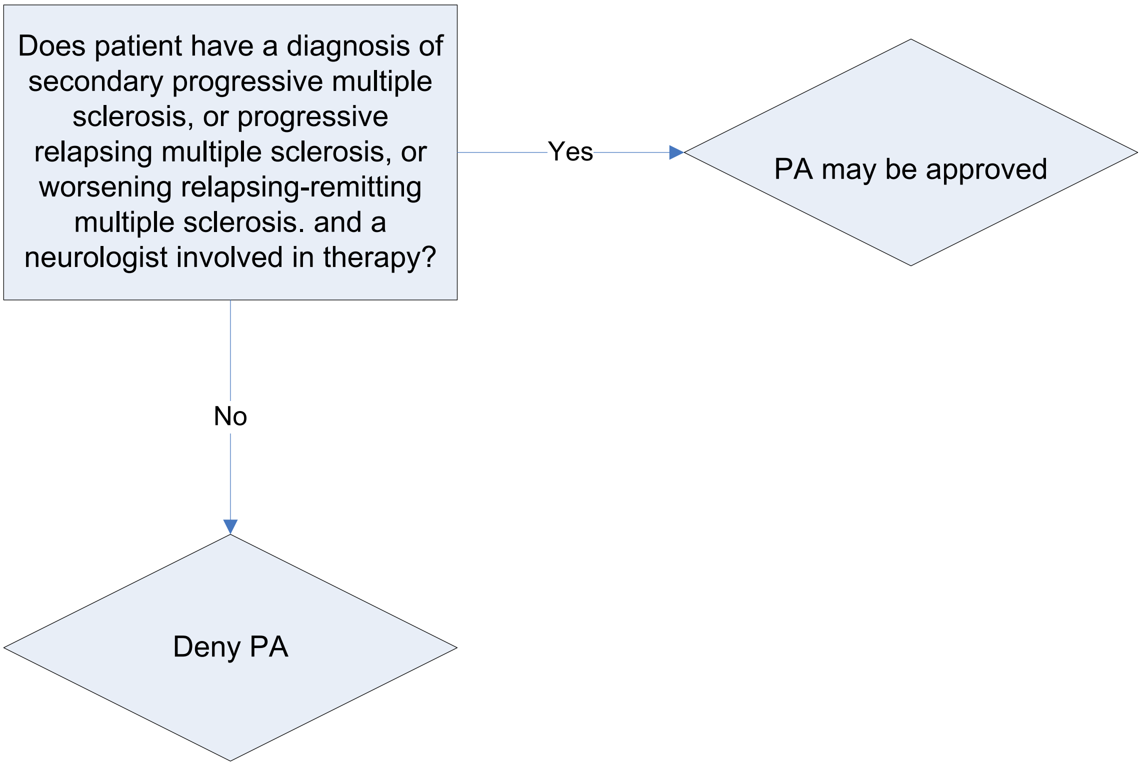
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Novantrone Prior Authorization Algorithm



TOPICAL KETOCONAZOLE PRODUCTS
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to: **866-254-0761** **For questions regarding this Prior authorization, call** **866-705-5391**

SD Medicaid requires that patients receiving a new prescription for Extina, Xolegel, and Ketocon Plus must first try a covered ketoconazole medication.

- **Ketoconazole creams and shampoos do not require a prior authorization.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Extina □ Xolegel □ Ketocon Plus	Medication Failed: Start Date: End Date:
PHYSICIAN SIGNATURE:	DATE:

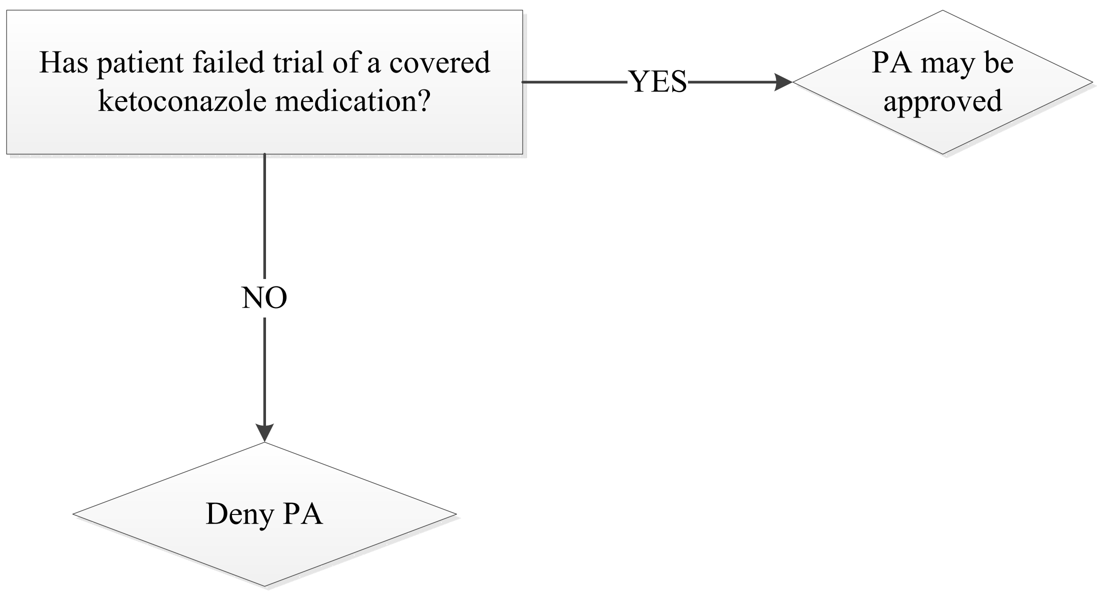
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Topical Ketoconazole Products Authorization Algorithm



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)	

PROTON PUMP INHIBITOR PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving proton pump inhibitors use **omeprazole, pantoprazole or lansoprazole** first line.

- **Omeprazole, pantoprazole or lansoprazole may be prescribed WITHOUT prior authorization.**
- **Prior authorization is NOT required for patients < 13 years of age**
- **Patients must use omeprazole, pantoprazole or lansoprazole for a minimum of 14 days for the trial to be considered a failure. Patient preference does not constitute treatment failure.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy)

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy)

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	
City:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN

REQUESTED DRUG:

- ❑ ACIPHEX
- ❑ NEXIUM
- ❑ PREVPAC
- ❑ PROTONIX
- ❑ ZEGERID
- ❑ DEXILANT

Requested Dosage: (must be completed)

Diagnosis:

- ❑ GERD
- ❑ H. pylori
- ❑ Hypersecretory conditions
- ❑ Peptic ulcer
- ❑ Duodenal ulcer
- ❑ Erosive esophagitis
- ❑ Barrett's esophagitis

Qualifications for coverage:

❑ Failed omeprazole, pantoprazole or lansoprazole

Was omeprazole/pantoprazole/lansoprazole trial for at least 14 days?
❑ YES ❑ NO

Dose:

Frequency:

❑ Adverse Reaction to omeprazole/pantoprazole/lansoprazole (attach FDA Medwatch form) or contraindicated (provide description below):

❑ Inability to take or tolerate oral tablets (must check a box below):

- ❑ Tube Fed
- ❑ Requires soft food or liquid administration

Other (provide description at right)

Physician Signature:	Date:

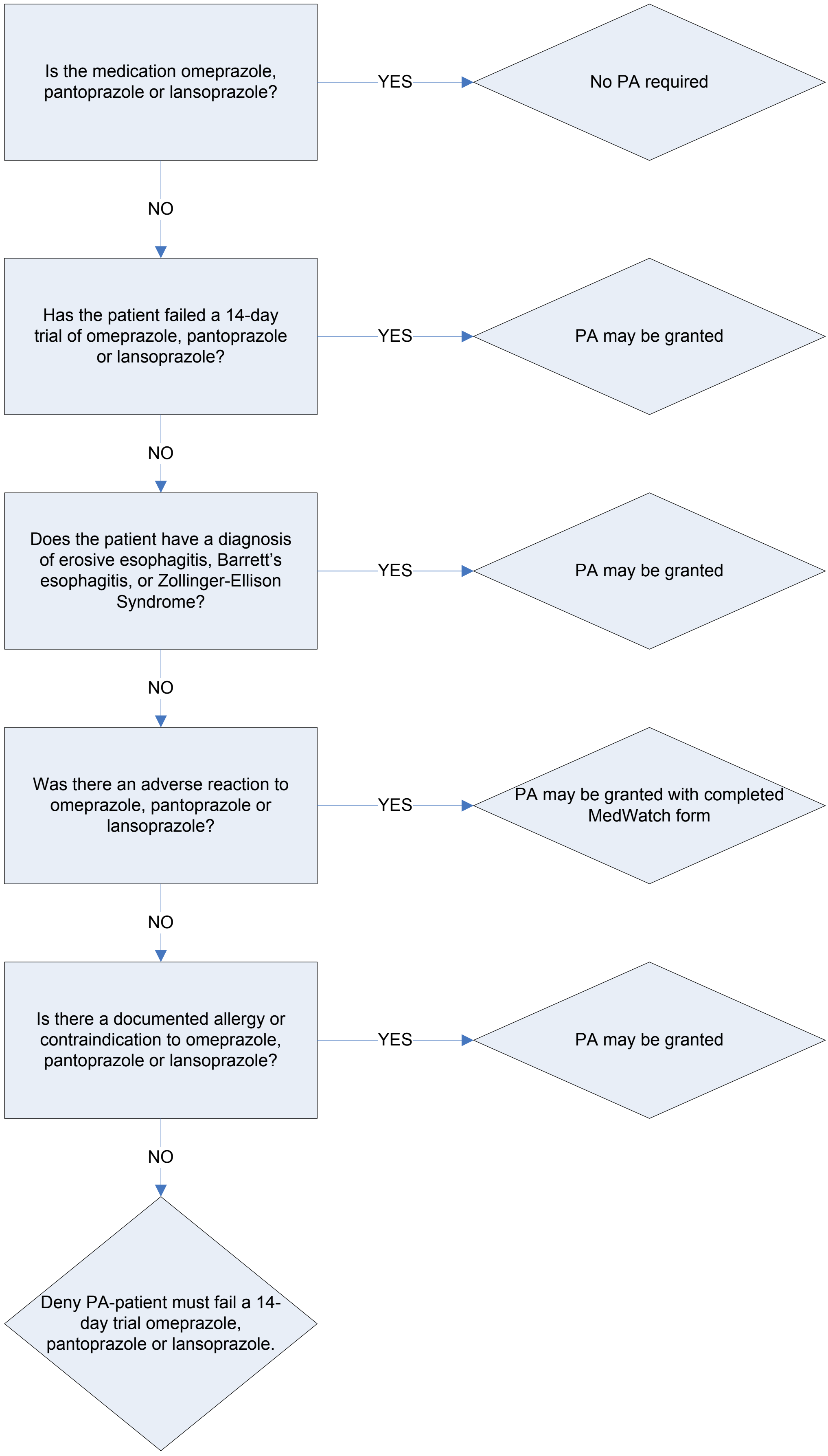
Part IV: TO BE COMPLETED BY PHARMACY

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Proton Pump Inhibitor Prior Authorization Criteria



ULTRAM ER/RYZOLT PRIOR AUTHORIZATION

SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients have a trial of tramadol before receiving a PA for Ultram ER or Ryzolt.

- **Patients must use generic tramadol for a minimum of 30 days for the trial to be considered a failure.**
- **Ultram ER and Ryzolt will have a quantity limit of 30 tablets per month.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
City:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Dosage: (must be completed)

Diagnosis for this request:

Qualifications for coverage:

❑ Patient is currently stable on Ultram ER/Ryzolt

❑ Failed trial of tramadol	Was tramadol trial for at least 30 days? ❑ YES ❑ NO	Tramadol Dose: Tramadol Frequency:

Adverse Reaction (attach FDA MedWatch form) or contraindication to tramadol: (provide description below):

Medical Justification for use of Ultram ER or Ryzolt without trial of tramadol:

Physician Signature: Date:

Part IV: PHARMACY INFORMATION

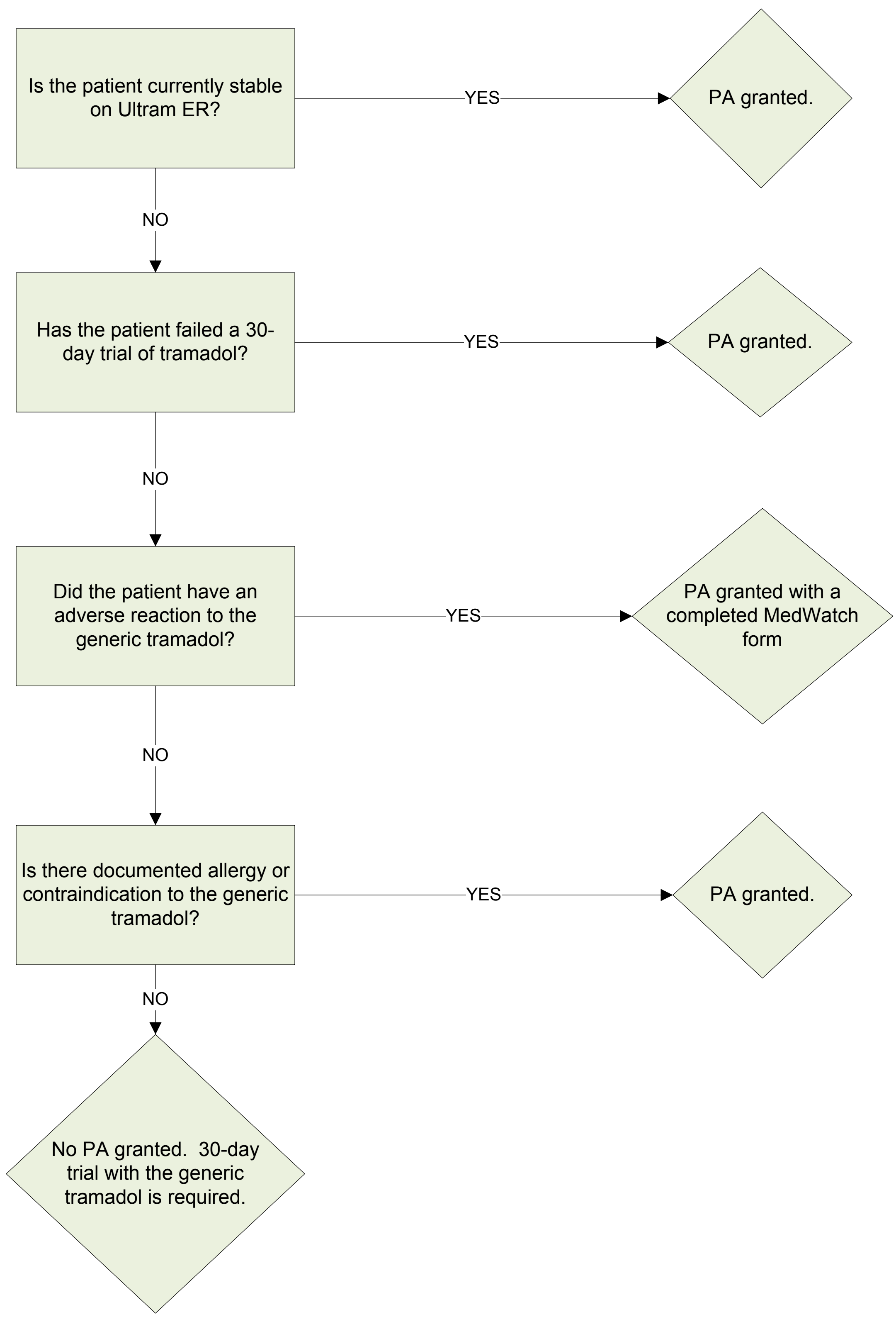
PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services

Ultram ER and Ryzolt
Criteria Algorithm



PRIOR AUTHORIZATION REQUEST FORM
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

☐ Antihistamines
☐ Proton Pump Inhibitors
☐ DAW Request
☐ Maximum Units Request
☐ Altabax
☐ Lindane/Malathion
☐ Ambien CR
☐ Ultram ER/Ryzolt
☐ ARBs
☐ Growth Hormone
☐ Vusion
☐ Xolair
☐ Other
☐ Amrix
☐ Fexmid
☐ Moxatag

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:
CITY:	PHONE:	FAX:

Part III: TO BE COMPLETED BY PHYSICIAN:

REQUESTED DRUG:	**Requested Dosage:** (must be completed)
	Diagnosis for this request:

QUALIFICATIONS FOR COVERAGE (Please include any additional relevant information):

Prior Therapies:	
Medical Justification:	
Adverse Reaction (attach FDA Medwatch form)or contraindication to drug requested: (please provide description below)	
Physician signature:	Date:

Part IV: PHARMACY INFORMATION

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

Revised 07/27/09

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? ☐ YES ☐ NO	PHONE:	FAX:

Part III: TO BE COMPLETED BY PHYSICIAN:

REQUESTED DRUG:	**Requested Dosage:** (must be completed)
☐ INITIAL REQUEST ☐ RENEWAL REQUEST	**Diagnosis for this request:**

QUALIFICATIONS FOR COVERAGE:

Does patient have a diagnosis of: ☐ Panhypopituitarism **OR** ☐ Prader-Willi Syndrome (If either, may skip questions 1, 2, & 3)

1. IGF-1 Level:

2. Provocative testing:

Type____________________ Results____________________ Date____________________

Type____________________ Results____________________ Date____________________

3. Has the patient been screened for intracranial malignancy or tumor? ☐ YES ☐ NO

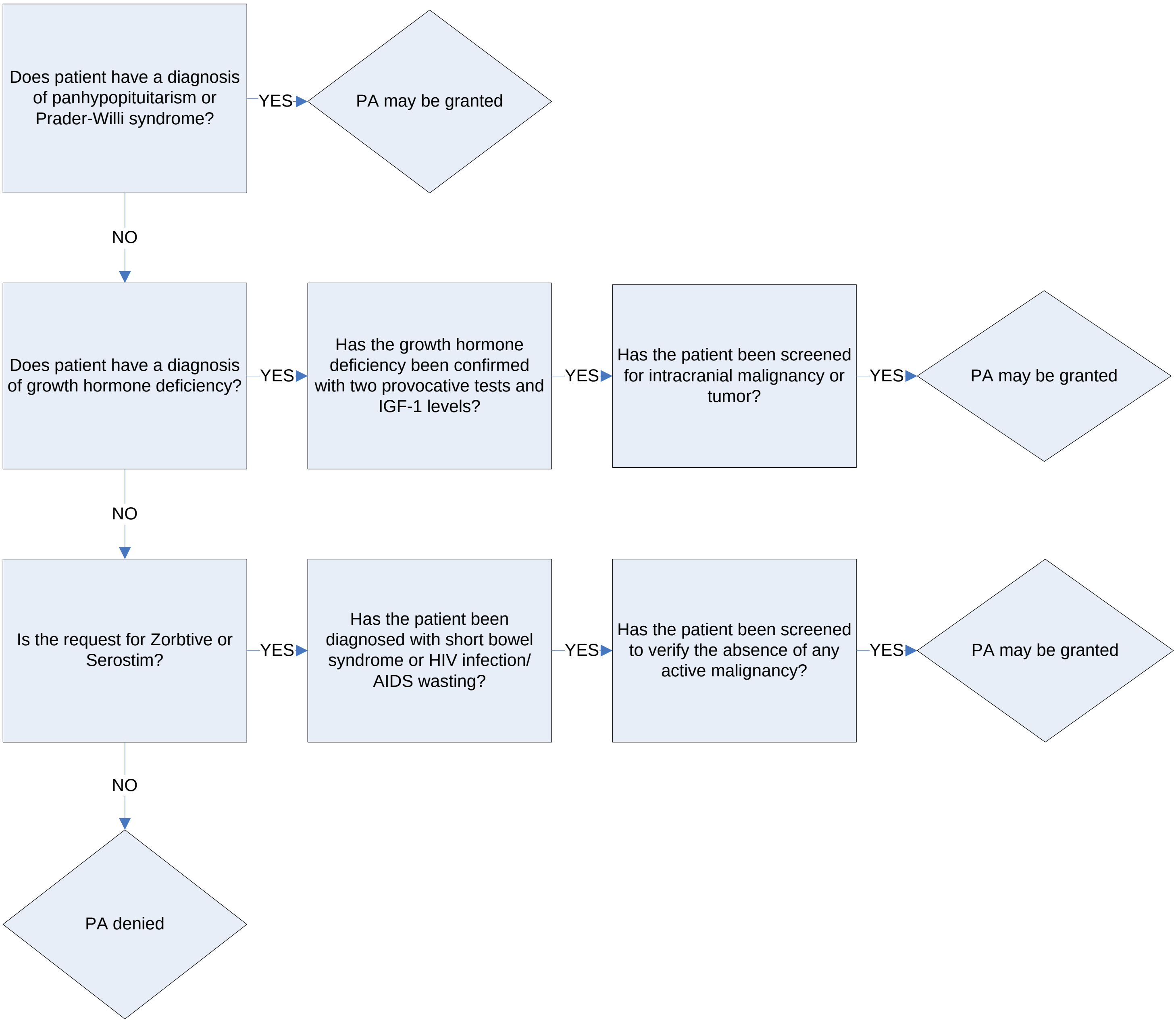
4. Does the patient have any of the following contraindications? Check all that apply.
   ☐ Proliferative Diabetic retinopathy ☐ Benign intracranial hypertension ☐ NONE

Physician signature:	Date:

Part IV: PHARMACY INFORMATION

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

South Dakota Department of Social Services
Adult Growth Hormone Criteria



ALTABAX PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a prescription for Altabax must first try and fail MUPIROCIN.

- **Patients must use generic mupirocin for a minimum of 5 days for the trial to be considered a failure.**
- **Patients diagnosed with MRSA may be approved to use Altabax first-line.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:			PHYSICIAN PROVIDER NUMBER:
City:	State:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Dosage: (must be completed)	**Diagnosis for this request:**
Qualifications for coverage:	
❑ Failed trial of mupirocin in the last 90 days	Was mupirocin trial for at least 5 days? ❑ YES ❑ NO
Adverse Reaction (attach FDA Medwatch form) or contraindication to mupirocin: (provide description below):	
Medical Justification for use of Altabax without trial of mupirocin:	
Physician Signature:	Date:

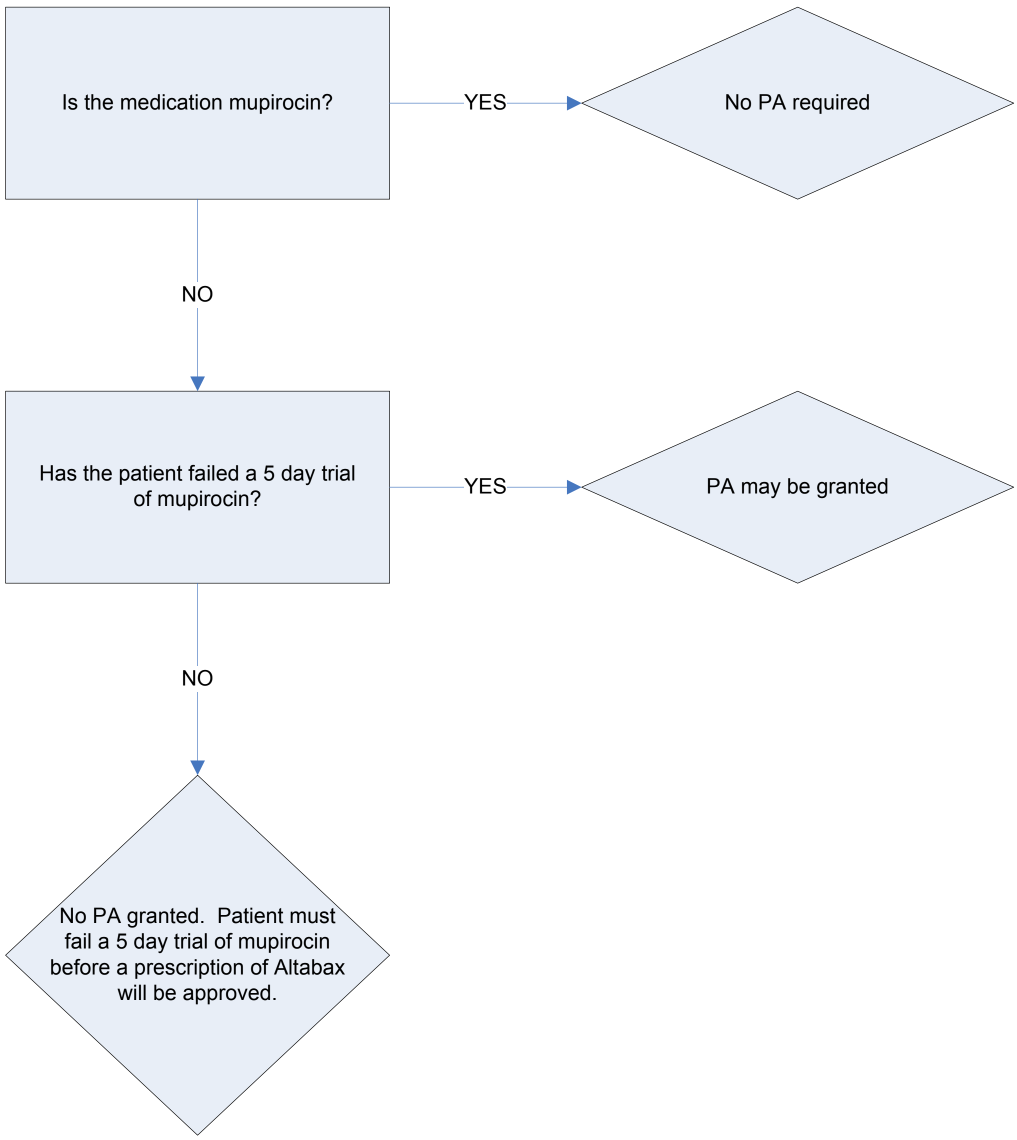
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Altabax Prior Authorization Criteria



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)	**Diagnosis for this request:**

Qualifications for coverage:

- ❑ IgE level (Give date of test and results) ______________________________

Adverse Reaction (attach FDA Medwatch form) or contraindication: (provide description below):

Medical Justification for use of Xolair without trial of inhaled corticosteroids:

Physician Signature: Date:

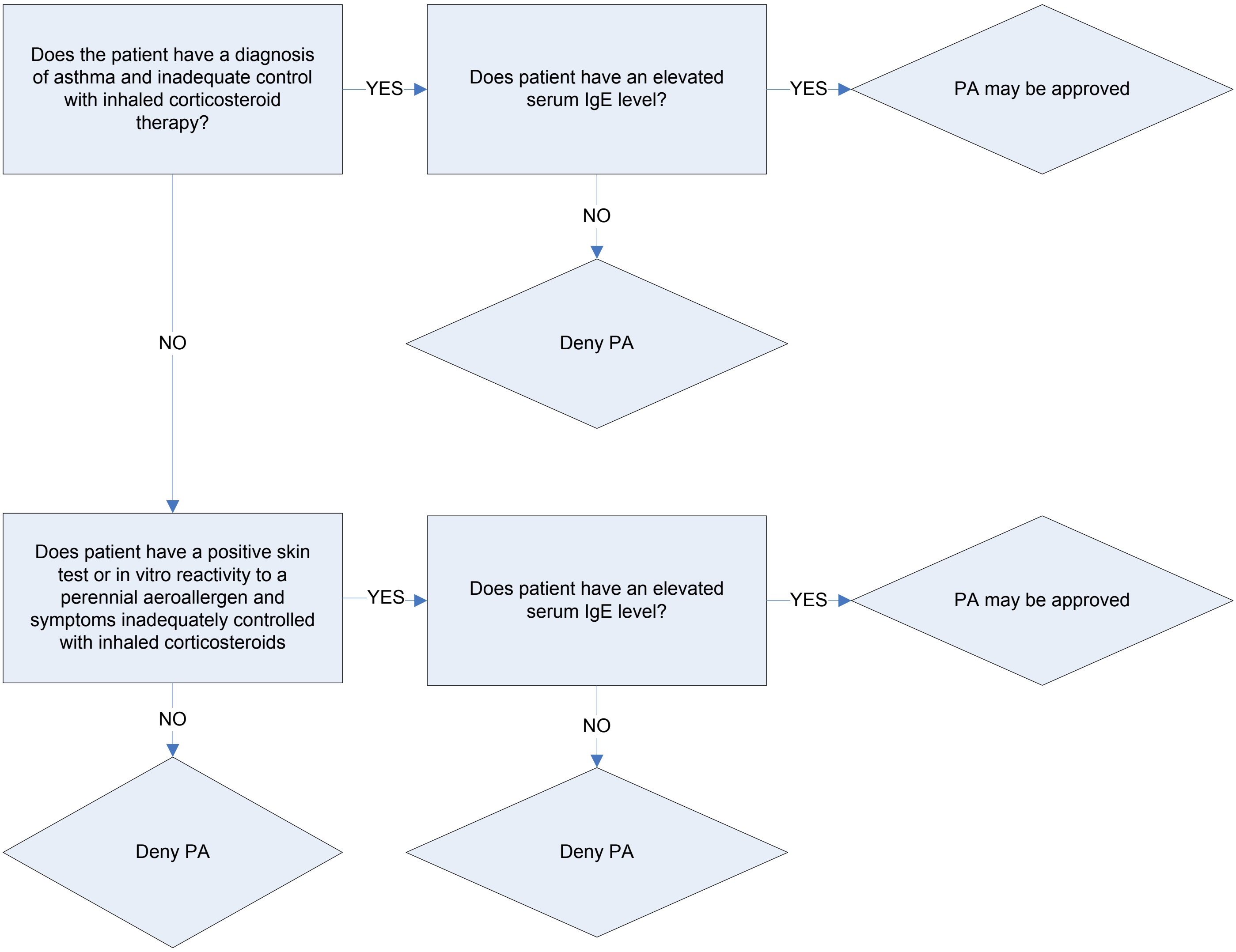
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Xolair Prior Authorization Criteria



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: End Date:	Dose: Frequency:

Adverse Reaction (attach FDA MedWatch form) or contraindication to inactive ingredients in amoxicillin: (provide description below):

Medical Justification for use of Moxatag without trial of amoxicillin:

Physician Signature: Date:

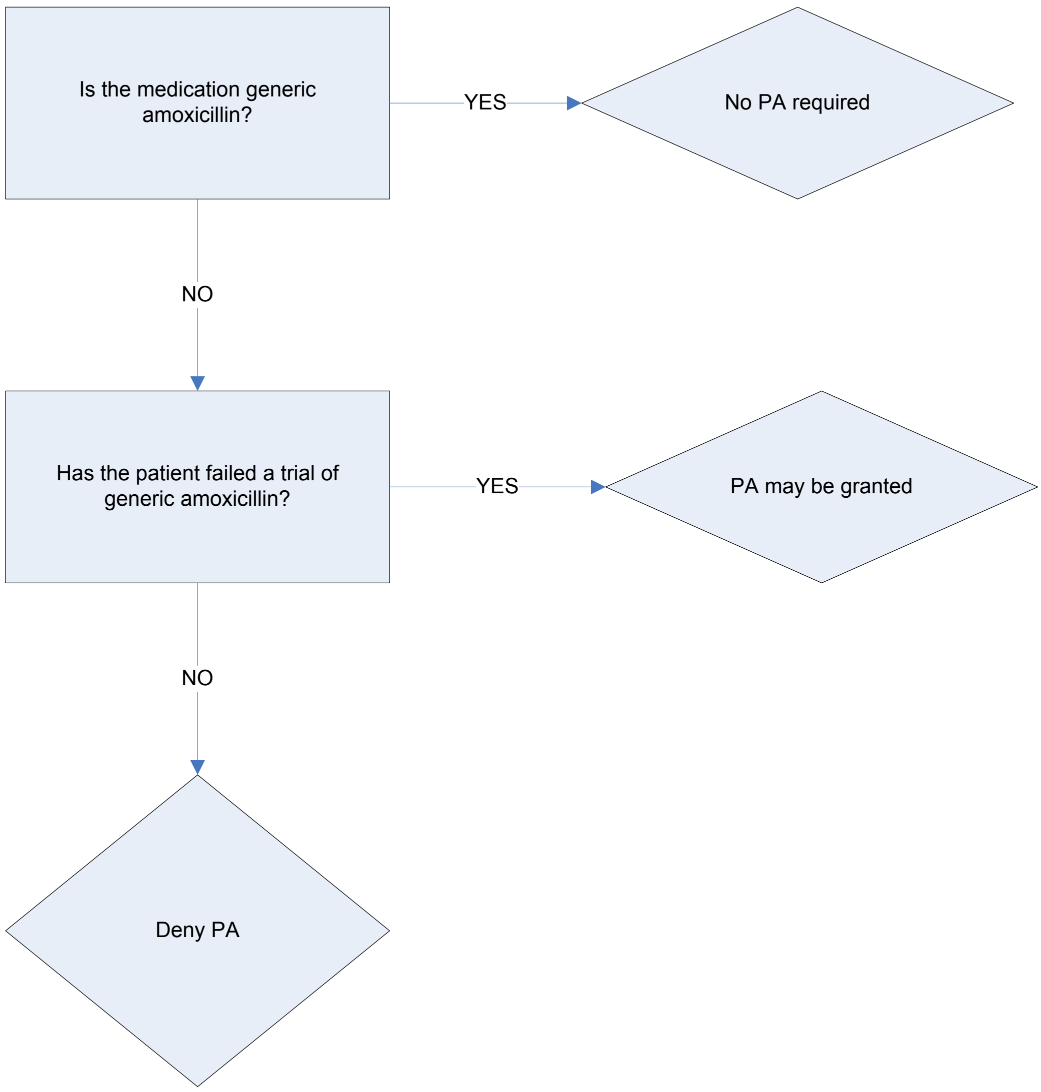
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Moxatag Prior Authorization Criteria



NUCYNTA **PRIOR AUTHORIZATION** SD DEPARTMENT OF SOCIAL SERVICES MEDICAL SERVICES DIVISION	**Fax Completed Form to:** **866-254-0761** **For questions regarding this Prior authorization, call** **866-705-5391**

SD Medicaid requires that patients receiving a new prescription for Nucynta must try an immediate release schedule-II opioid as first line therapy.

- **Nucynta should only be used as a second line agent for opioid naïve patients following failure with other immediate release schedule-II opioids.**
- **Immediate release oxycodone, oxymorphone, hydromorphone, and meperidine do not require a prior authorization.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage:			Diagnosis for this request:	
☐ Failed Therapy	Dose	Frequency	Start Date	End Date
PHYSICIAN SIGNATURE:				DATE:

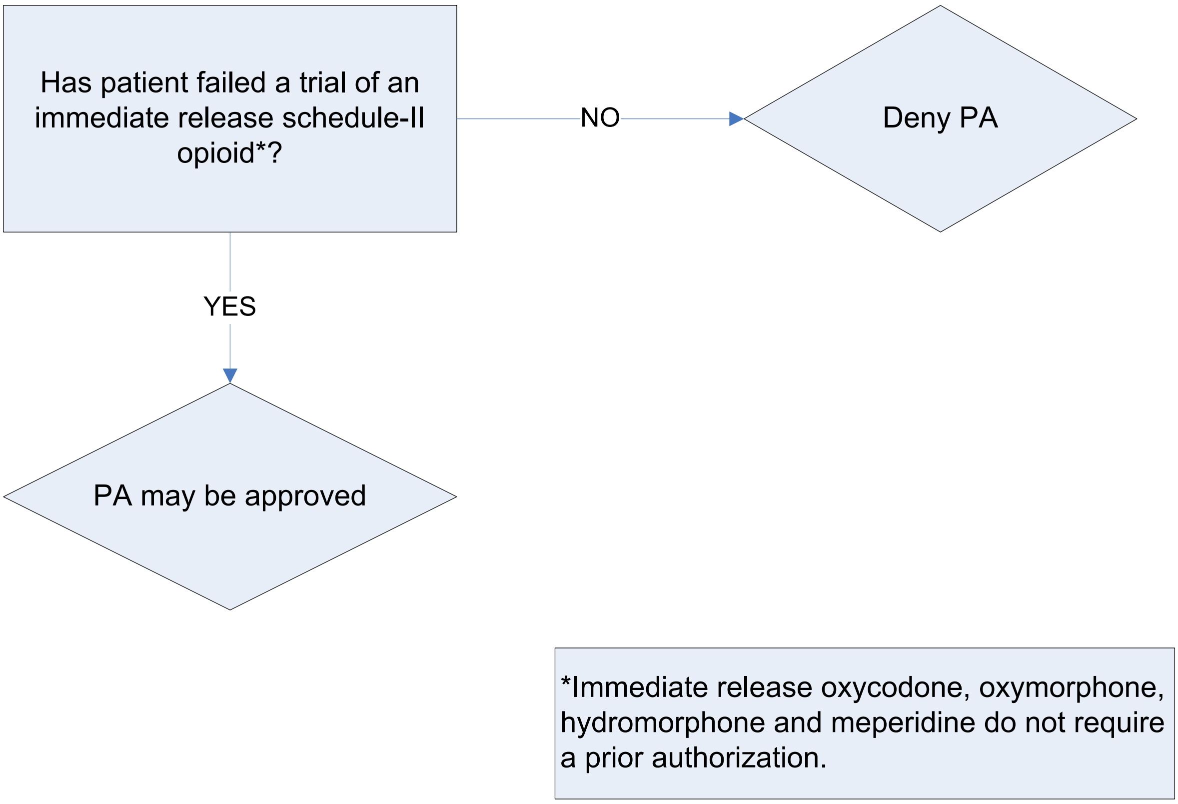
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Nucynta Prior Authorization Algorithm



ORACEA and SOLODYN
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Oracea or Solodyn must try a first line agent.

- **Doxycycline, minocycline, and tetracycline do not require a prior authorization.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage:			Diagnosis for this request:	
□ Failed Therapy	Dose	Frequency	Start Date	End Date
PHYSICIAN SIGNATURE:				DATE:

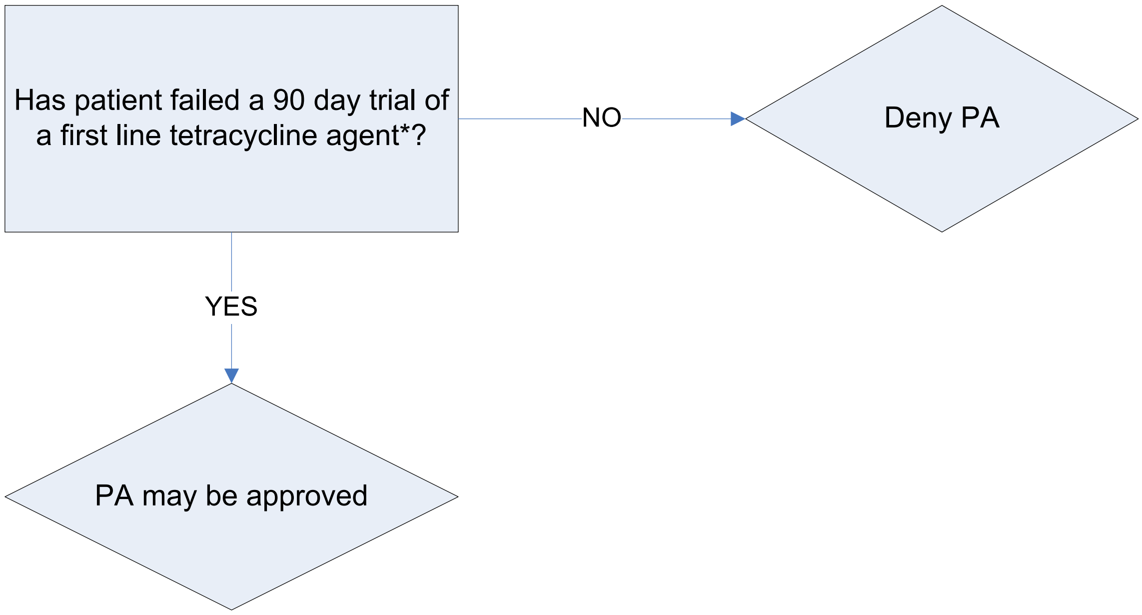
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

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



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

SANCUSO/GRANISOL/ZUPLENZ
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Sancuso, Granisol or Zuplenz must first try other anti-nausea medications.

- **Patients must use a generic 5-hydroxytryptamine-3 receptor antagonist or other anti-nausea medication for at least 14 days for the trial to be considered a failure.**
- **Patients must be receiving moderately and/or highly emetogenic chemotherapy for up to 5 consecutive days.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Sancuso ________________________ □ Granisol ________________________ □ Zuplenz ________________________	Patient able to tolerate oral medications: Failed medication ____ Was trial for at least 14 days? □ YES □ NO
□ Patient unable to tolerate oral medications (Sancuso only)	
PHYSICIAN SIGNATURE:	DATE:

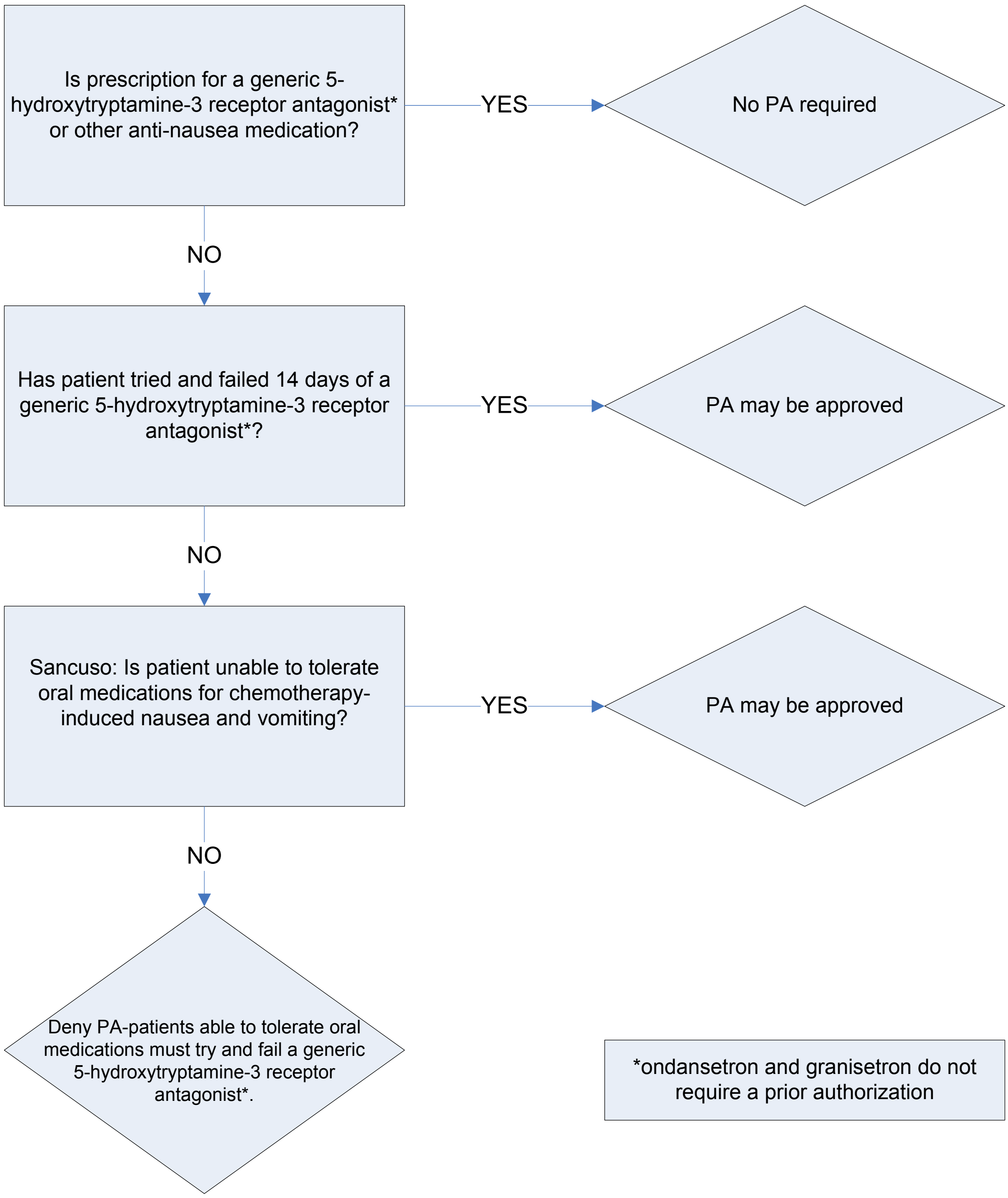
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

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



SUBOXONE/SUBUTEX PA FORM
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

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

- **Patient must be 16 years or older.**
- **Indicated for use in treatment of documented opioid dependence.**
- **Must not be taking other opioids, tramadol, or carisoprodol concurrently.**
- **Prescriber must be registered to prescribe Suboxone/Subutex under the Substance Abuse and Mental Health Services Administration (SAMHSA).**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy)

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy)

PHYSICIAN NAME:	SAMHSA ID (X-DEA Number)	PHYSICIAN MEDICAID ID NUMBER:
City:	FAX: ( )	Phone: ( )

Part III: TO BE COMPLETED BY PHYSICIAN

REQUESTED DRUG:	**Requested Dosage:** (must be completed)
	Diagnosis for this request:

Qualifications for coverage:

Patient 16 years of age or older? ❑ YES ❑ NO

Patient taking other opioids, tramadol, or carisoprodol concurrently? ❑ YES ❑ NO

Physician Signature:	Date:

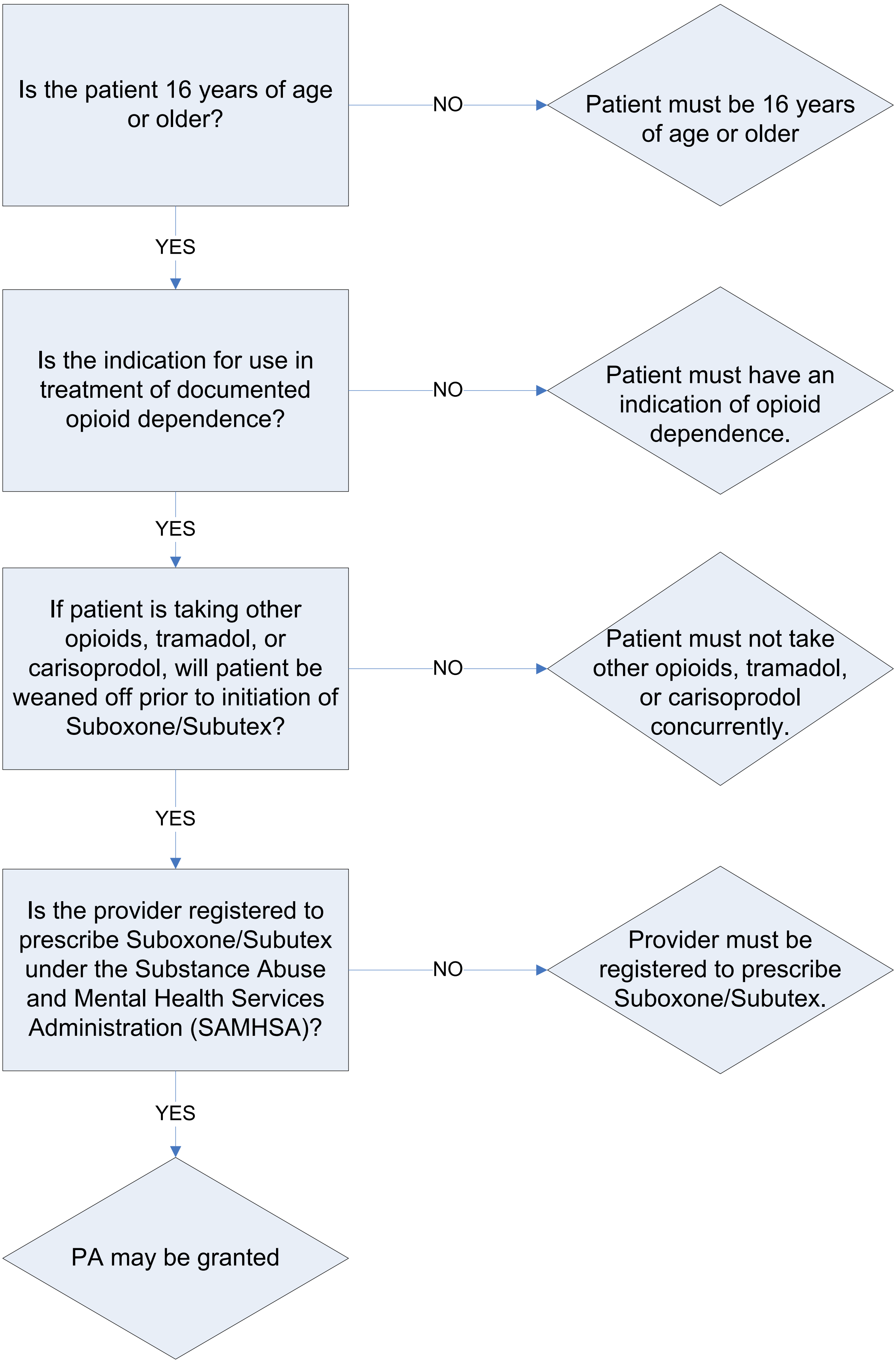
Part IV: TO BE COMPLETED BY PHARMACY

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

Part V: FOR OFFICIAL USE ONLY

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

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



SOMA 250 PA FORM
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Soma 250 must meet the following criteria:

- **Patient must first use carisoprodol 350mg.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy)

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy)

PHYSICIAN NAME:	PHYSICIAN MEDICAID ID NUMBER:	
City:	FAX: ( )	Phone: ( )

Part III: TO BE COMPLETED BY PHYSICIAN

REQUESTED DRUG:	**Requested Dosage:** (must be completed)
	Diagnosis for this request:

Qualifications for coverage:

☐ Failed carisoprodol therapy	Start Date	End Date	Dose	Frequency

Physician Signature:	Date:

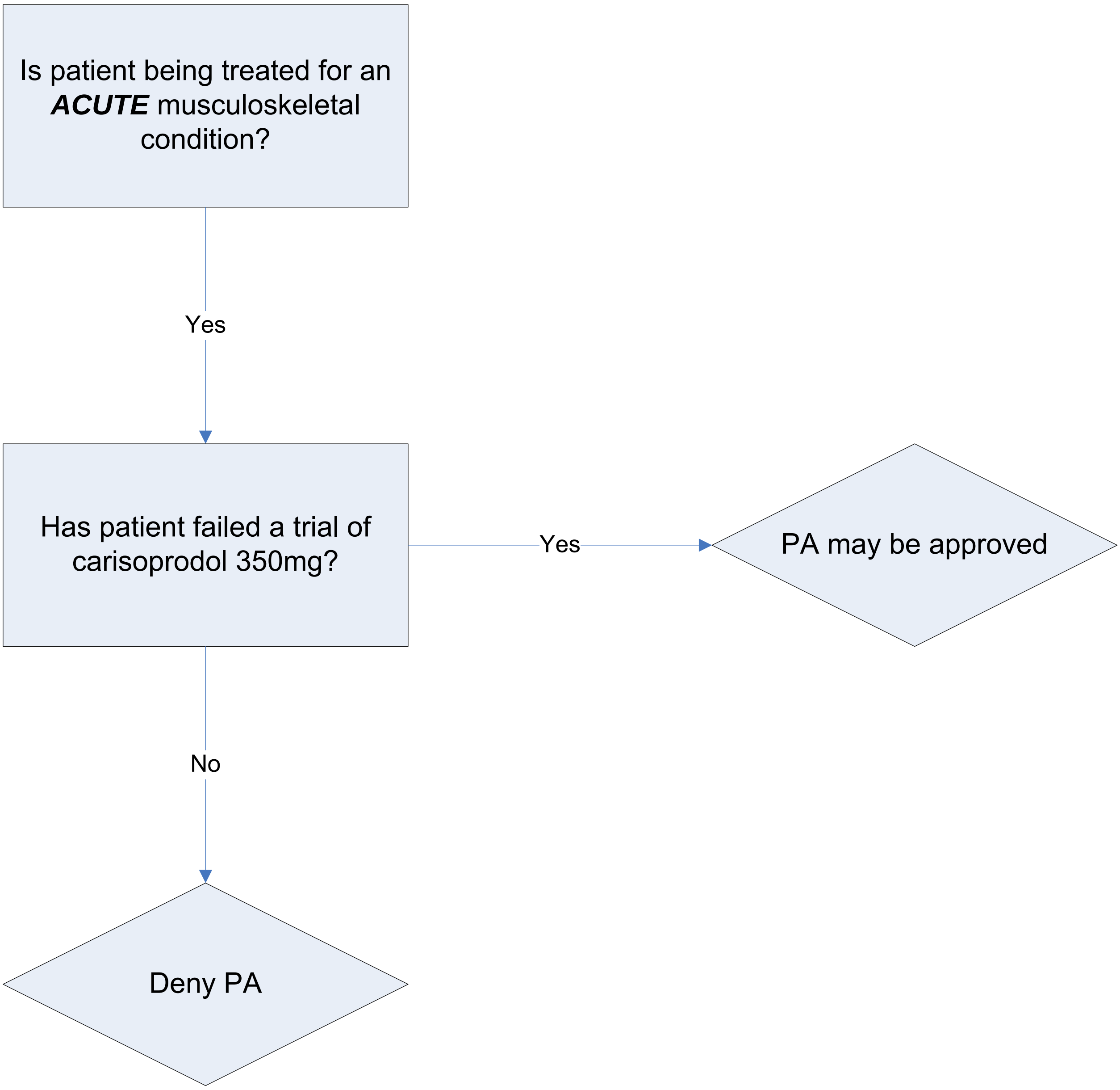
Part IV: TO BE COMPLETED BY PHARMACY

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

Part V: FOR OFFICIAL USE ONLY

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

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



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) considered to be an alternate dosage form (e.g., rapid dissolve tablets, injectables) or an isomer/metabolite of a covered agent must first try and fail one of the agents listed below.

- Traditional antipsychotics (first generation) do not require a prior authorization.
- Abilify (aripiprazole), Zyprexa (olanzapine), Seroquel (quetiapine), Geodon (ziprasidone), clozapine, and risperidone do not require a prior authorization when written for their standard tablet/capsule dosage form.
- 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: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: (must be completed) **Diagnosis for this request:**	
Qualifications for coverage:	
☐ Unable to swallow the standard tablet/capsule dosage form	☐ Currently being discharged from an inpatient mental health facility
Adverse Reaction (attach FDA MedWatch form) or contraindication: (provide description below):	
Medical Justification for use of alternate dosage forms or isomers/metabolites of a covered agent without trial of a tier one agent:	
Physician Signature:	**Date:**

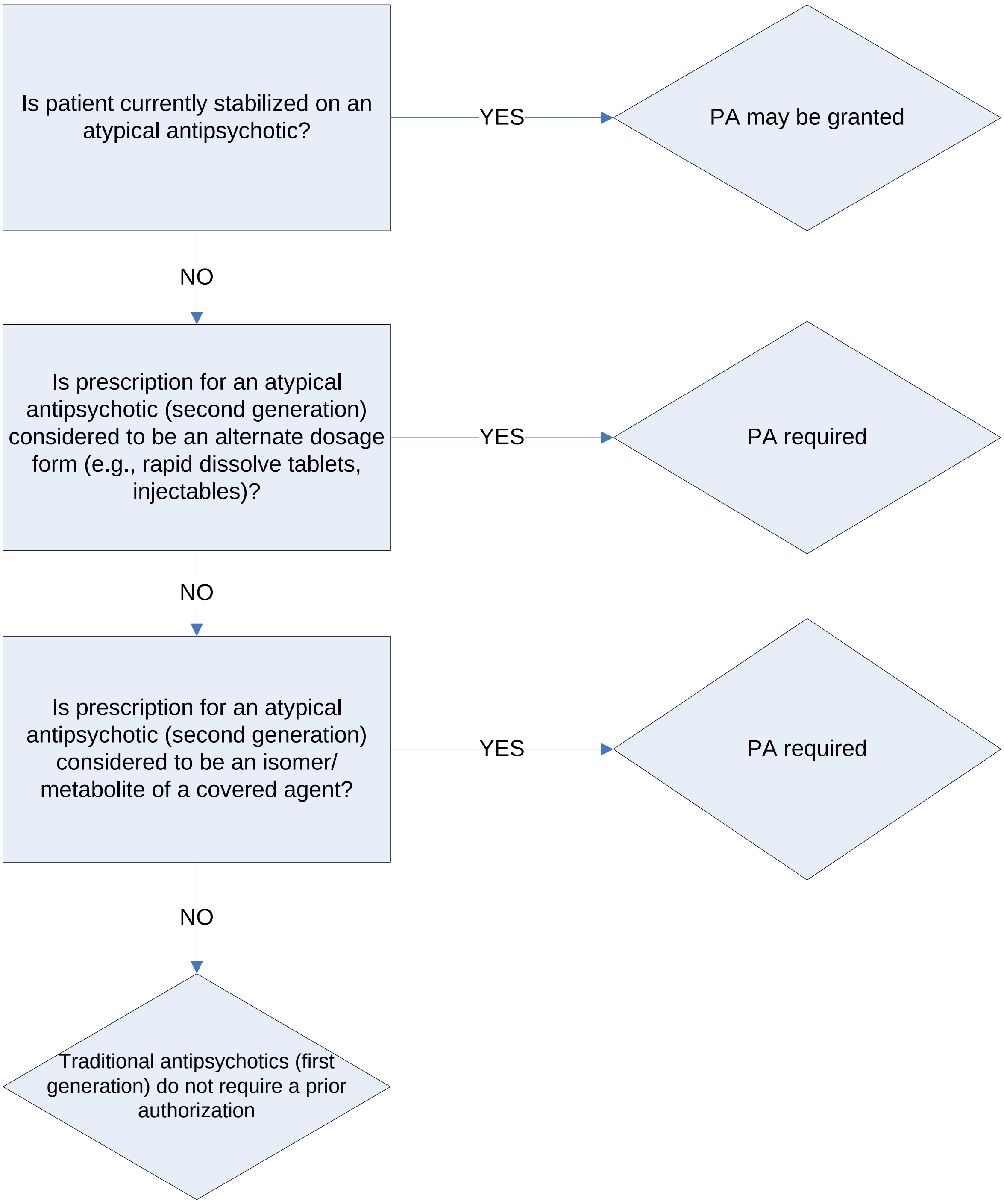
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Atypical Antipsychotics Authorization Criteria



XYREM PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

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

- **Patient must be 16 years of age or older.**
- **Patient must have a diagnosis of narcolepsy with cataplexy.**
- **Patient must have a diagnosis of narcolepsy with excessive daytime sleepiness with previous trial and failure of a standard stimulant agent (modafinil, armodafinil, methylphenidate, dextroamphetamine, or amphetamine/dextroamphetamine).**
- **Patient must be enrolled in the Xyrem Success Program.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN MEDICAID PROVIDER NUMBER:
PHYSICIAN ADDRESS:		
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug: (must be completed) **Diagnosis for this request:**			
Qualifications for coverage:			
☐ Failed stimulant therapy (list drug)	Start Date:	End Date:	Dose:
☐ Enrolled in Xyrem Success Program	Date:		
Physician Signature:			Date:

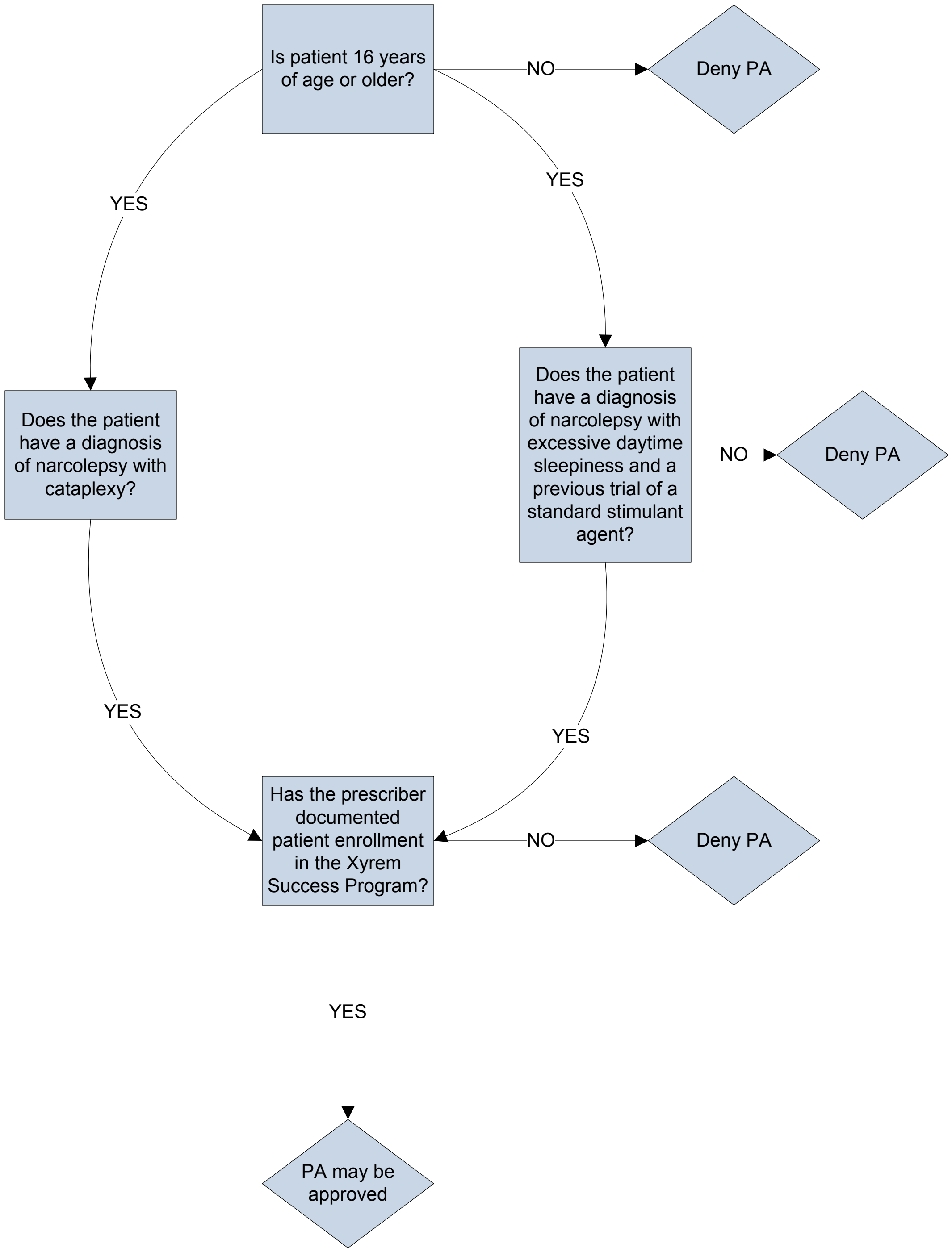
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Xyrem Prior Authorization Criteria



QUALAQUIN
PRIOR AUTHORIZATION

SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Qualaquin must have a diagnosis of malaria.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Qualaquin	Diagnosis for this request:
PHYSICIAN SIGNATURE:	DATE:

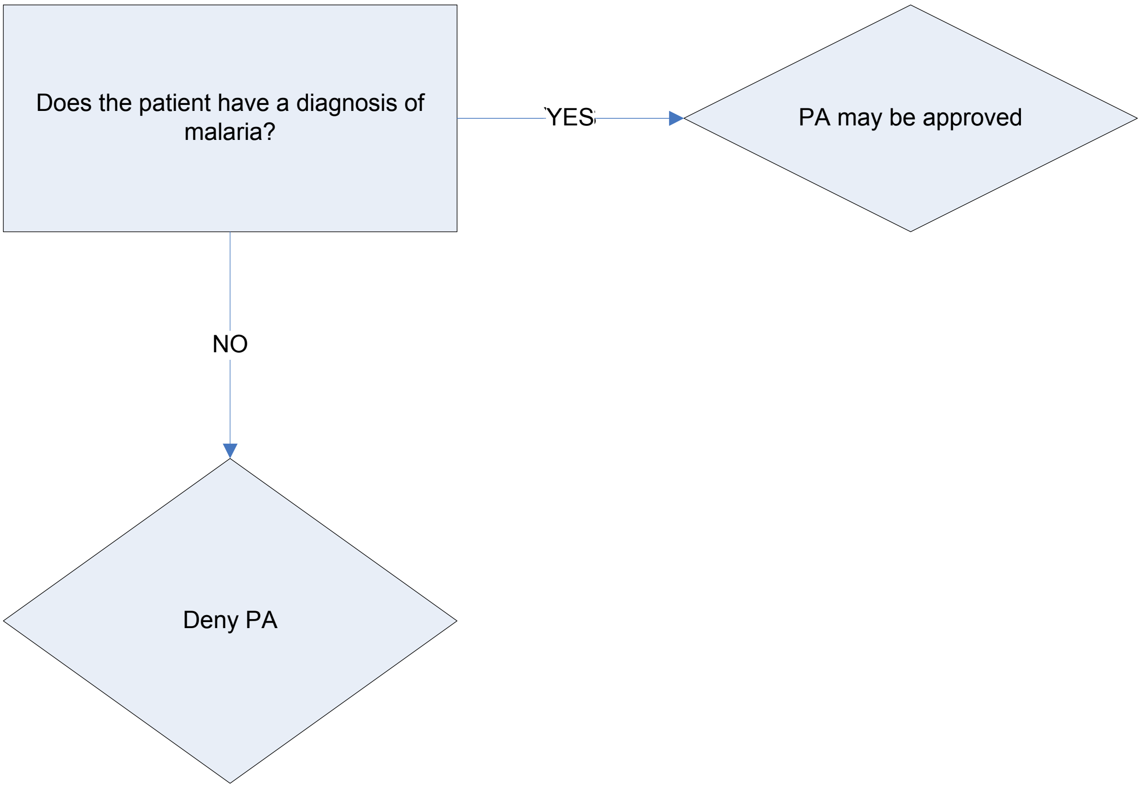
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Qualaquin Prior Authorization Algorithm



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 sezures?	□ Yes	□ No
PHYSICIAN SIGNATURE:		DATE:

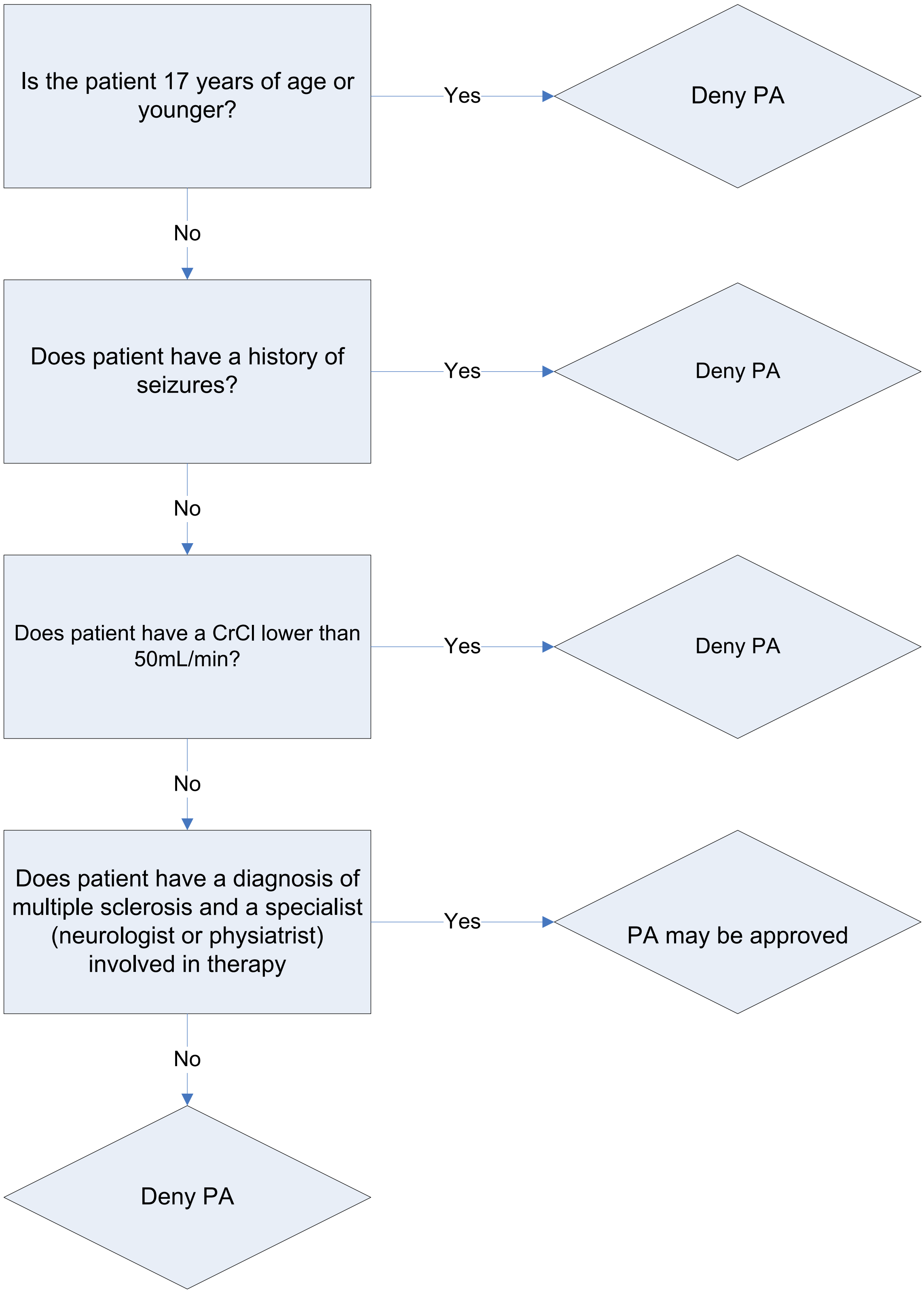
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Ampyra Prior Authorization Algorithm



GILENYA
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

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

- **Patient must have a confirmed diagnosis of relapsing multiple sclerosis.**
- **Patient must have a neurologist involved in therapy.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	NEUROLOGIST INVOLVED IN THERAPY:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Gilenya ________________________	Diagnosis for this request:
PHYSICIAN SIGNATURE:	DATE:

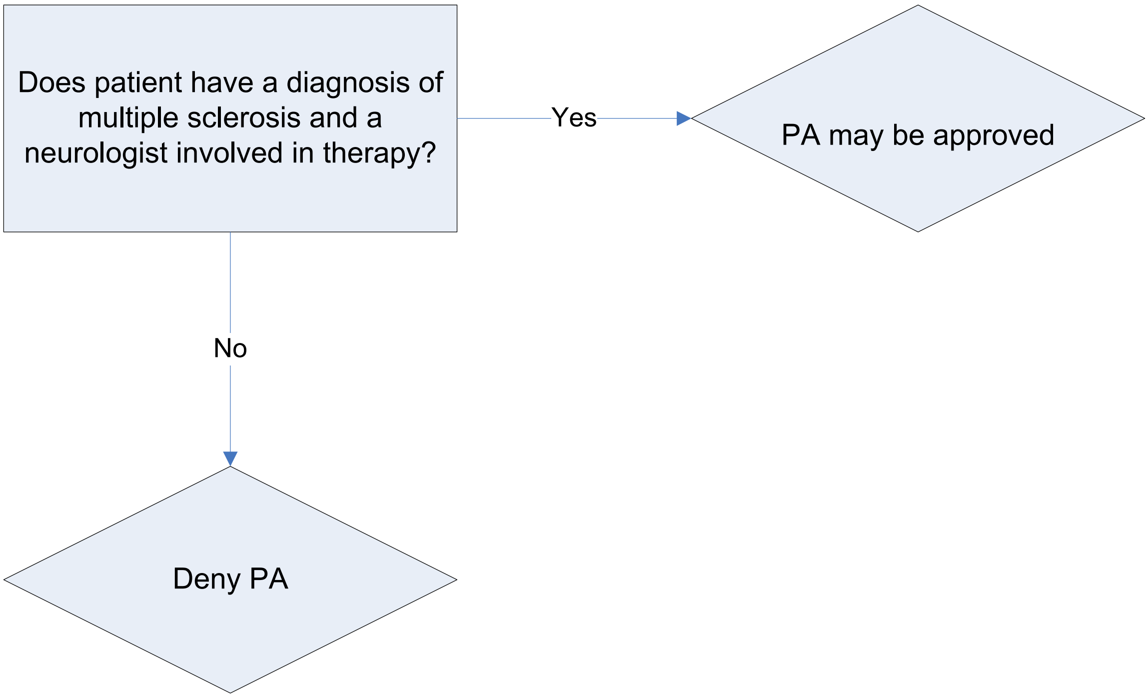
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Gilenya Prior Authorization Algorithm



TYSABRI
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

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

- **Patient must have a confirmed diagnosis of relapsing multiple sclerosis (MS) or moderate to severe Crohn's Disease.**
- **Patient is 18 years of age or older.**
- **Patient must have a neurologist or gastroenterologist involved in therapy.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	NEUROLOGIST/GASTROENTEROLOGIST INVOLVED IN THERAPY:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Tysabri ________________________	Diagnosis for this request:
PHYSICIAN SIGNATURE:	DATE:

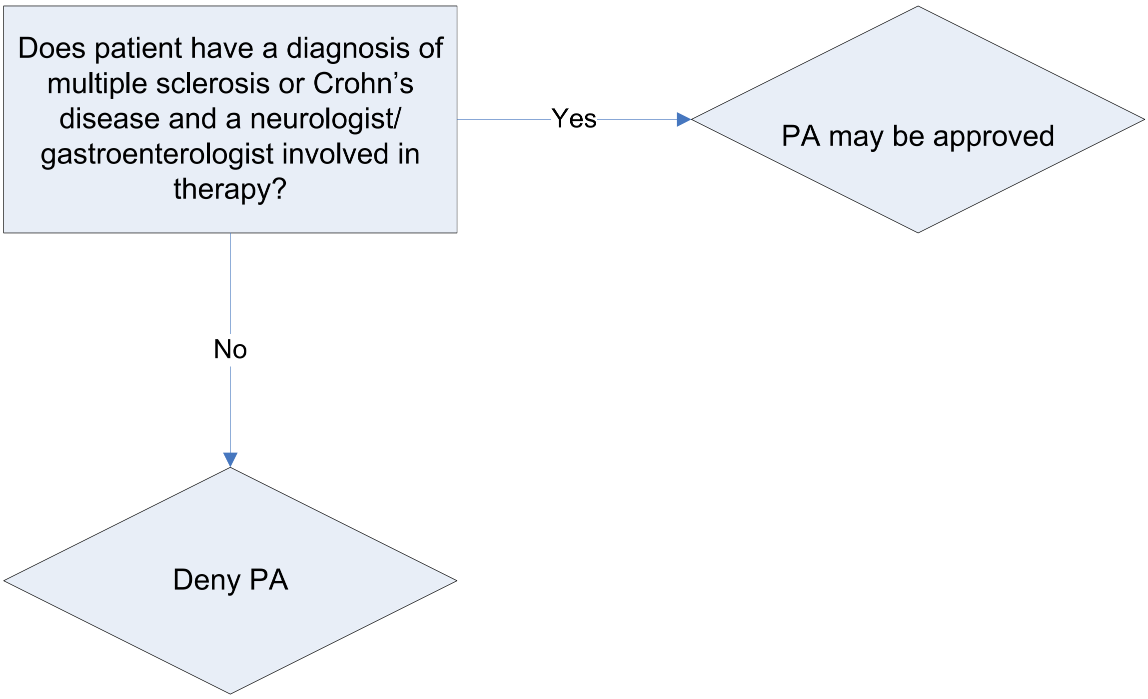
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Tysabri Prior Authorization Algorithm



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 or Xarelto 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**	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)

SD ODT Utilization			
12/01/10 - 11/30/11			
Label Name	**Rx Num**	**Total Reimb**	**Avg Cost per Script**
ABILIFY DISCMELT 10 MG TABLET	13	$7,856.52	$604.35
ABILIFY DISCMELT 15 MG TABLET	2	$1,137.96	$568.98
ALLEGRA ODT 30 MG TABLET	5	$541.75	$108.35
ANASPAZ 0.125 MG TABLET ODT	7	$164.59	$23.51
CLARINEX 2.5 MG REDITABS	16	$2,195.97	$137.25
CLARINEX 5 MG REDITABS	31	$3,439.16	$110.94
CLONAZEPAM 0.25 MG ODT	69	$4,084.59	$59.20
CLONAZEPAM 0.5 MG DIS TABLET	114	$3,876.51	$34.00
CLONAZEPAM 1 MG DIS TABLET	103	$4,784.67	$46.45
CLONAZEPAM 2 MG ODT	1	$19.25	$19.25
FAZACLO 100 MG ODT	115	$32,900.49	$286.09
FAZACLO 150 MG ODT	11	$4,359.93	$396.36
FAZACLO 200 MG ODT	1	$77.58	$77.58
FAZACLO 25 MG ODT	59	$5,808.97	$98.46
HYOMAX-FT 0.125 MG CHEW MELT	12	$551.91	$45.99
HYOMAX-SL 0.125 MG TABLET SL	44	$2,276.16	$51.73
HYOSCYAMINE 0.125 MG ODT	12	$347.21	$28.93
HYOSCYAMINE 0.125 MG TAB SL	55	$2,539.66	$46.18
LAMICTAL 25 MG DISPER TABLET	8	$5,349.18	$668.65
LAMICTAL ODT 100 MG TABLET	8	$1,540.47	$192.56
LAMICTAL ODT 200 MG TABLET	22	$5,691.30	$258.70
LAMICTAL ODT 25 MG TABLET	8	$3,042.46	$380.31
LAMICTAL ODT 50 MG TABLET	8	$1,281.96	$160.25
LAMICTAL ODT START KT (ORANGE)	1	$251.64	$251.64
LAMOTRIGINE 25 MG DISPER TAB	276	$13,899.14	$50.36
LAMOTRIGINE 5 MG DISPER TABLET	44	$2,372.63	$53.92
MAXALT MLT 10 MG TABLET	318	$43,339.48	$136.29
MAXALT MLT 5 MG TABLET	77	$9,865.06	$128.12
METOZOLV ODT 5 MG TABLET	1	$15.52	$15.52
MIRTAZAPINE 15 MG ODT	43	$1,531.35	$35.61
MIRTAZAPINE 30 MG ODT	31	$1,201.11	$38.75
MIRTAZAPINE 45 MG ODT	21	$779.95	$37.14
ONDANSETRON ODT 4 MG TABLET	2574	$30,566.21	$11.87
ONDANSETRON ODT 8 MG TABLET	479	$10,490.63	$21.90
ORAPRED ODT 10 MG TABLET	11	$942.13	$85.65
ORAPRED ODT 15 MG TABLET	74	$6,496.47	$87.79
ORAPRED ODT 30 MG TABLET	15	$1,401.28	$93.42
PREVACID 15 MG SOLUTAB	626	$101,714.84	$162.48
PREVACID 30 MG SOLUTAB	177	$25,856.63	$146.08
RISPERDAL M-TAB 4 MG ODT	1	$501.43	$501.43
RISPERIDONE 0.5 MG ODT	27	$1,907.04	$70.63
RISPERIDONE 1 MG ODT	17	$2,063.06	$121.36
RISPERIDONE 2 MG ODT	25	$2,238.68	$89.55
RISPERIDONE 4 MG ODT	4	$1,217.14	$304.29

SD ODT Utilization			
12/01/10 - 11/30/11			
Label Name	**Rx Num**	**Total Reimb**	**Avg Cost per Script**
RISPERIDONE M-TAB 0.5 MG ODT	32	$2,808.52	$87.77
RISPERIDONE M-TAB 1 MG ODT	4	$731.14	$182.79
RISPERIDONE M-TAB 2 MG ODT	10	$1,324.52	$132.45
RISPERIDONE M-TAB 3 MG ODT	19	$7,858.56	$413.61
RISPERIDONE M-TAB 4 MG ODT	1	$297.07	$297.07
RYBIX ODT 50 MG TABLET	1	$193.13	$193.13
SYMAX FASTABS 0.125 MG TABLET	4	$15.78	$3.95
ZOFRAN ODT 4 MG TABLET	1	$7.79	$7.79
ZOFRAN ODT 8 MG TABLET	1	$25.93	$25.93
ZOMIG ZMT 2.5 MG TABLET	4	$514.69	$128.67
ZOMIG ZMT 5 MG TABLET	7	$754.91	$107.84
ZYPREXA ZYDIS 10 MG TABLET	116	$63,982.92	$551.58
ZYPREXA ZYDIS 15 MG TABLET	95	$76,353.90	$803.73
ZYPREXA ZYDIS 20 MG TABLET	90	$104,660.46	$1,162.89
ZYPREXA ZYDIS 5 MG TABLET	64	$24,433.56	$381.77
2,915 recipients	**6015**	**$636,482.55**	

ODT Summary by Age

Age	Recip Count	Rx
0	67	91
1	147	219
2	181	237
3	141	203
4	116	160
5	119	194
6	92	160
7	107	149
8	93	163
9	76	168
10	75	171
11	53	108
12	63	174
13	44	88
14	51	75
15	49	135
16	85	187
17	88	184
18	101	168
19	85	178
20	66	141
21	59	99
22	66	92
23	56	107
24	62	145
25	67	118
26	54	126
27	52	79
28	40	64
29	51	151
30	30	49
31	43	79
32	24	104
33	27	60
34	15	33
35	26	62
36	26	71
37	16	87
38	14	21
39	22	57
40	18	21
41	22	97
42	17	25
43	15	39

ODT Summary by Age

Age	Recip	Rx
44	9	26
45	8	27
46	11	36
47	13	51
48	9	24
49	9	54
50	10	19
51	11	42
52	9	58
53	11	34
54	15	37
55	9	21
56	14	67
57	7	40
58	4	13
59	11	16
60	3	11
61	8	23
62	7	13
63	9	31
64	5	22
65	1	1
67	1	1

Orally Disintegrating Tablets (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 who are prescribed an orally disintegrating tablet must first try a more cost-effective dosage form.

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:	Unable to Swallow: 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)	

Prepared by Health Information Designs, Inc.
February 13, 2012

South Dakota Medicaid
Aripiprazole/Quetiapine Utilization
March 2, 2012

In 4th quarter 2011, aripiprazole was the leading drug based on claims cost. There were 1,422 prescriptions reported at a cost of $664,028.50. This averages out to approximately $467 per prescription. In fourth quarter 2011, quetiapine XR had 272 prescriptions reported at a cost of $100,729.50. This averages out to approximately $370 per prescription.

Aripiprazole is indicated for use in the treatment of schizophrenia, acute treatment of manic or mixed episodes associated with bipolar I disorder as monotherapy and as an adjunct to lithium or valproate, as maintenance treatment of bipolar I disorder, both as monotherapy and as an adjunct to lithium or valproate, adjunctive treatment of major depressive disorder (MDD), treatment of irritability associated with autistic disorder, and acute treatment of agitation associated with schizophrenia or bipolar I disorder.

Quetiapine XR is indicated for use in the treatment of schizophrenia, acute treatment of manic or mixed episodes associated with bipolar I disorder, both as monotherapy and as an adjunct to lithium or divalproex, acute treatment of depressive episodes associated with bipolar disorder, maintenance treatment of bipolar I disorder as an adjunct to lithium or divalproex, and adjunctive treatment of major depressive disorder (MDD).

During the December 2011 P&T meeting, the Commitee requested information about the number of patients using aripiprazole for treatment of depression.

Aripiprazole 12/01/10 to 11/30/11			
	Number of Prescriptions	Total Paid Amount	Unique Number of Recipients
All Patients	5,873	$2,675,746	995
Patients with a diagnosis of depression (311) but no diagnosis of bipolar (296) or schizophrenia (295) on file.	461	$190,758	100
Patients with NO FDA approved diagnosis on file – depression (311), bipolar (296), schizophrenia (295), or autism (299).	738	$298,440	130

Quetiapine XR 12/01/10 to 11/30/01			
	Number of Prescriptions	Total Paid Amount	Unique Number of Recipients
All Patients	1,175	$425,152	196
Patients with a diagnosis of depression (311) but no diagnosis of bipolar (296) or schizophrenia (295) on file.	81	$17,670	20
Patients with NO FDA approved diagnosis on file – depression (311), bipolar (296), or schizophrenia (295)	180	$45,828.24	26

Antipsychotic Utilization		
12/01/10 - 11/30/11		
Label Name	**Rx Num**	**Total Reimb Amt**
ABILIFY 1 MG/ML SOLUTION	35	$3,999.73
ABILIFY 10 MG TABLET	1232	$559,855.49
ABILIFY 15 MG TABLET	784	$295,694.62
ABILIFY 2 MG TABLET	624	$308,850.55
ABILIFY 20 MG TABLET	522	$326,828.88
ABILIFY 30 MG TABLET	278	$185,403.89
ABILIFY 5 MG TABLET	2383	$986,118.71
ABILIFY DISCMELT 10 MG TABLET	13	$7,856.52
ABILIFY DISCMELT 15 MG TABLET	2	$1,137.96
CHLORPROMAZINE 10 MG TABLET	1	$9.65
CHLORPROMAZINE 100 MG TABLET	33	$802.26
CHLORPROMAZINE 25 MG TABLET	35	$698.51
CHLORPROMAZINE 50 MG TABLET	31	$420.57
CLOZAPINE 100 MG TABLET	1115	$70,243.77
CLOZAPINE 200 MG TABLET	428	$60,064.69
CLOZAPINE 25 MG TABLET	281	$9,259.87
CLOZAPINE 50 MG TABLET	168	$6,797.93
CLOZARIL 100 MG TABLET	33	$24,968.92
CLOZARIL 25 MG TABLET	13	$1,967.62
FANAPT 2 MG TABLET	4	$114.69
FANAPT 4 MG TABLET	2	$1,179.64
FANAPT 6 MG TABLET	5	$1,703.52
FANAPT 8 MG TABLET	3	$1,743.79
FAZACLO 100 MG ODT	115	$32,900.49
FAZACLO 150 MG ODT	11	$4,359.93
FAZACLO 200 MG ODT	1	$77.58
FAZACLO 25 MG ODT	59	$5,808.97
FLUPHENAZINE 10 MG TABLET	16	$202.30
FLUPHENAZINE 2.5 MG TABLET	1	$12.21
FLUPHENAZINE 5 MG TABLET	11	$215.38
GEODON 20 MG CAPSULE	144	$34,608.34
GEODON 40 MG CAPSULE	353	$100,341.14
GEODON 60 MG CAPSULE	267	$122,806.22
GEODON 80 MG CAPSULE	576	$286,313.81
HALOPERIDOL 0.5 MG TABLET	31	$295.15
HALOPERIDOL 1 MG TABLET	69	$581.57
HALOPERIDOL 10 MG TABLET	31	$1,908.58
HALOPERIDOL 2 MG TABLET	69	$662.65
HALOPERIDOL 5 MG TABLET	56	$925.76
INVEGA ER 3 MG TABLET	127	$54,841.15
INVEGA ER 6 MG TABLET	144	$67,270.76
INVEGA ER 9 MG TABLET	82	$55,901.70
INVEGA SUSTENNA 117 MG PREF SY	144	$122,328.17
INVEGA SUSTENNA 156 MG PREF SY	69	$73,529.08
INVEGA SUSTENNA 234 MG PREF SY	164	$261,709.89
INVEGA SUSTENNA 39 MG PREF SYR	9	$2,946.60
INVEGA SUSTENNA 78 MG PREF SYR	1	$1,036.43
LATUDA 40 MG TABLET	167	$70,484.53
LATUDA 80 MG TABLET	35	$15,274.10
LOXAPINE 10 MG CAPSULE	14	$329.43

Antipsychotic Utilization		
12/01/10 - 11/30/11		
Label Name	**Rx Num**	**Total Reimb Amt**
LOXAPINE 25 MG CAPSULE	10	$462.25
LOXAPINE 50 MG CAPSULE	12	$803.55
OLANZAPINE 10 MG TABLET	14	$7,521.91
OLANZAPINE 15 MG TABLET	10	$10,357.24
OLANZAPINE 2.5 MG TABLET	5	$816.42
OLANZAPINE 20 MG TABLET	21	$24,882.04
OLANZAPINE 5 MG TABLET	19	$7,950.03
OLANZAPINE 7.5 MG TABLET	4	$1,529.02
OLANZAPINE ODT 10 MG TABLET	4	$2,238.50
OLANZAPINE ODT 15 MG TABLET	5	$3,149.50
OLANZAPINE ODT 20 MG TABLET	5	$5,218.10
OLANZAPINE ODT 5 MG TABLET	4	$1,159.16
PERPHENAZINE 2 MG TABLET	10	$472.60
PERPHENAZINE 4 MG TABLET	30	$1,973.21
PERPHENAZINE 8 MG TABLET	3	$133.97
RISPERDAL 0.5 MG TABLET	3	$32.79
RISPERDAL 1 MG TABLET	60	$9,779.69
RISPERDAL 1 MG/ML SOLUTION	5	$105.05
RISPERDAL 3 MG TABLET	11	$3,584.41
RISPERDAL CONSTA 12.5 MG SYR	2	$540.82
RISPERDAL CONSTA 25 MG SYR	68	$25,439.60
RISPERDAL CONSTA 37.5 MG SYR	132	$99,200.00
RISPERDAL CONSTA 50 MG SYR	214	$181,277.95
RISPERDAL M-TAB 4 MG ODT	1	$501.43
RISPERIDONE 0.25 MG TABLET	1042	$15,822.70
RISPERIDONE 0.5 MG ODT	27	$1,907.04
RISPERIDONE 0.5 MG TABLET	1837	$27,394.14
RISPERIDONE 1 MG ODT	17	$2,063.06
RISPERIDONE 1 MG TABLET	2162	$32,830.63
RISPERIDONE 1 MG/ML SOLUTION	291	$10,193.74
RISPERIDONE 2 MG ODT	25	$2,238.68
RISPERIDONE 2 MG TABLET	1041	$19,003.37
RISPERIDONE 3 MG TABLET	555	$9,484.61
RISPERIDONE 4 MG ODT	4	$1,217.14
RISPERIDONE 4 MG TABLET	279	$5,171.09
RISPERIDONE M-TAB 0.5 MG ODT	32	$2,808.52
RISPERIDONE M-TAB 1 MG ODT	4	$731.14
RISPERIDONE M-TAB 2 MG ODT	10	$1,324.52
RISPERIDONE M-TAB 3 MG ODT	19	$7,858.56
RISPERIDONE M-TAB 4 MG ODT	1	$297.07
SAPHRIS 10 MG TAB SUBLINGUAL	10	$724.33
SAPHRIS 5 MG TABLET SUBLINGUAL	21	$6,303.50
SEROQUEL 100 MG TABLET	1597	$308,468.45
SEROQUEL 200 MG TABLET	1004	$379,845.86
SEROQUEL 25 MG TABLET	875	$121,472.96
SEROQUEL 300 MG TABLET	952	$566,544.07
SEROQUEL 400 MG TABLET	485	$327,845.25
SEROQUEL 50 MG TABLET	1231	$252,718.21
SEROQUEL XR 150 MG TABLET	177	$54,791.32
SEROQUEL XR 200 MG TABLET	189	$48,943.04

Antipsychotic Utilization		
12/01/10 - 11/30/11		
Label Name	**Rx Num**	**Total Reimb Amt**
SEROQUEL XR 300 MG TABLET	366	$154,498.77
SEROQUEL XR 400 MG TABLET	193	$120,319.06
SEROQUEL XR 50 MG TABLET	250	$46,600.80
THIORIDAZINE 10 MG TABLET	5	$92.37
THIORIDAZINE 100 MG TABLET	39	$1,197.60
THIORIDAZINE 50 MG TABLET	7	$128.15
THIOTHIXENE 10 MG CAPSULE	8	$153.94
THIOTHIXENE 2 MG CAPSULE	3	$79.05
THIOTHIXENE 5 MG CAPSULE	12	$203.44
TRIFLUOPERAZINE 1 MG TABLET	15	$450.96
TRIFLUOPERAZINE 10 MG TABLET	1	$46.75
TRIFLUOPERAZINE 2 MG TABLET	28	$811.65
TRIFLUOPERAZINE 5 MG TABLET	29	$684.95
ZYPREXA 10 MG TABLET	438	$247,055.15
ZYPREXA 10 MG VIAL	1	$44.14
ZYPREXA 15 MG TABLET	312	$300,819.18
ZYPREXA 2.5 MG TABLET	106	$30,070.80
ZYPREXA 20 MG TABLET	311	$390,811.30
ZYPREXA 5 MG TABLET	441	$171,193.16
ZYPREXA 7.5 MG TABLET	70	$32,669.45
ZYPREXA ZYDIS 10 MG TABLET	116	$63,982.92
ZYPREXA ZYDIS 15 MG TABLET	95	$76,353.90
ZYPREXA ZYDIS 20 MG TABLET	90	$104,660.46
ZYPREXA ZYDIS 5 MG TABLET	64	$24,433.56
3,158 recipients	**28330**	**$8,537,887.45**

Antipsychotic Utilization-Depression Diagnosis		
12/01/10 - 11/30/11		
Label Name	**Rx Num**	**Total Reimb**
ABILIFY 10 MG TABLET	775	$356,119.48
ABILIFY 15 MG TABLET	482	$184,140.73
ABILIFY 2 MG TABLET	283	$140,523.42
ABILIFY 20 MG TABLET	309	$203,940.60
ABILIFY 30 MG TABLET	167	$109,875.69
ABILIFY 5 MG TABLET	1379	$575,768.44
ABILIFY DISCMELT 15 MG TABLET	2	$1,137.96
CHLORPROMAZINE 10 MG TABLET	1	$9.65
CHLORPROMAZINE 100 MG TABLET	21	$441.30
CHLORPROMAZINE 25 MG TABLET	20	$541.76
CHLORPROMAZINE 50 MG TABLET	15	$231.32
CLOZAPINE 100 MG TABLET	580	$30,896.01
CLOZAPINE 200 MG TABLET	170	$24,913.58
CLOZAPINE 25 MG TABLET	101	$2,570.12
CLOZAPINE 50 MG TABLET	90	$4,001.93
CLOZARIL 100 MG TABLET	7	$4,725.04
FANAPT 2 MG TABLET	4	$114.69
FANAPT 4 MG TABLET	2	$1,179.64
FANAPT 6 MG TABLET	5	$1,703.52
FAZACLO 100 MG ODT	35	$10,947.33
FAZACLO 150 MG ODT	10	$4,298.31
FAZACLO 200 MG ODT	1	$77.58
FAZACLO 25 MG ODT	27	$2,298.79
FLUPHENAZINE 10 MG TABLET	11	$141.80
FLUPHENAZINE 5 MG TABLET	10	$194.08
GEODON 20 MG CAPSULE	100	$24,426.15
GEODON 40 MG CAPSULE	233	$70,050.63
GEODON 60 MG CAPSULE	163	$72,909.35
GEODON 80 MG CAPSULE	346	$178,989.91
HALOPERIDOL 0.5 MG TABLET	24	$213.15
HALOPERIDOL 1 MG TABLET	59	$511.82
HALOPERIDOL 10 MG TABLET	23	$1,518.51
HALOPERIDOL 2 MG TABLET	45	$470.04
HALOPERIDOL 5 MG TABLET	46	$823.67
INVEGA ER 3 MG TABLET	59	$25,965.91
INVEGA ER 6 MG TABLET	80	$39,654.25
INVEGA ER 9 MG TABLET	55	$37,288.89
INVEGA SUSTENNA 117 MG PREF SY	114	$98,383.32
INVEGA SUSTENNA 156 MG PREF SY	56	$59,658.71
INVEGA SUSTENNA 234 MG PREF SY	99	$158,106.20
INVEGA SUSTENNA 39 MG PREF SYR	9	$2,946.60
INVEGA SUSTENNA 78 MG PREF SYR	1	$1,036.43
LATUDA 40 MG TABLET	118	$49,993.81
LATUDA 80 MG TABLET	13	$5,583.46

Antipsychotic Utilization-Depression Diagnosis		
12/01/10 - 11/30/11		
Label Name	**Rx Num**	**Total Reimb**
LOXAPINE 10 MG CAPSULE	14	$329.43
LOXAPINE 25 MG CAPSULE	10	$462.25
LOXAPINE 50 MG CAPSULE	12	$803.55
OLANZAPINE 10 MG TABLET	9	$4,517.17
OLANZAPINE 15 MG TABLET	5	$5,109.40
OLANZAPINE 2.5 MG TABLET	2	$145.65
OLANZAPINE 20 MG TABLET	10	$11,606.46
OLANZAPINE 5 MG TABLET	9	$4,114.38
OLANZAPINE 7.5 MG TABLET	3	$1,183.50
OLANZAPINE ODT 10 MG TABLET	2	$897.12
OLANZAPINE ODT 15 MG TABLET	3	$1,978.47
OLANZAPINE ODT 20 MG TABLET	1	$870.40
OLANZAPINE ODT 5 MG TABLET	3	$831.31
PERPHENAZINE 2 MG TABLET	8	$425.90
PERPHENAZINE 4 MG TABLET	24	$1,519.46
PERPHENAZINE 8 MG TABLET	3	$133.97
RISPERDAL 0.5 MG TABLET	3	$32.79
RISPERDAL 1 MG TABLET	14	$2,342.25
RISPERDAL CONSTA 25 MG SYR	44	$13,712.18
RISPERDAL CONSTA 37.5 MG SYR	61	$42,842.81
RISPERDAL CONSTA 50 MG SYR	144	$117,810.97
RISPERIDONE 0.25 MG TABLET	358	$5,803.26
RISPERIDONE 0.5 MG ODT	12	$621.69
RISPERIDONE 0.5 MG TABLET	808	$12,019.55
RISPERIDONE 1 MG ODT	4	$312.40
RISPERIDONE 1 MG TABLET	981	$15,463.42
RISPERIDONE 1 MG/ML SOLUTION	13	$1,854.10
RISPERIDONE 2 MG ODT	22	$1,971.98
RISPERIDONE 2 MG TABLET	536	$9,632.82
RISPERIDONE 3 MG TABLET	225	$3,475.23
RISPERIDONE 4 MG TABLET	158	$3,005.45
RISPERIDONE M-TAB 0.5 MG ODT	2	$98.09
RISPERIDONE M-TAB 2 MG ODT	5	$422.58
RISPERIDONE M-TAB 3 MG ODT	7	$1,474.91
SAPHRIS 10 MG TAB SUBLINGUAL	1	$557.19
SAPHRIS 5 MG TABLET SUBLINGUAL	4	$1,488.61
SEROQUEL 100 MG TABLET	1048	$206,144.39
SEROQUEL 200 MG TABLET	675	$242,191.34
SEROQUEL 25 MG TABLET	537	$76,864.67
SEROQUEL 300 MG TABLET	685	$429,976.51
SEROQUEL 400 MG TABLET	327	$218,188.08
SEROQUEL 50 MG TABLET	829	$174,804.90
SEROQUEL XR 150 MG TABLET	153	$48,077.35
SEROQUEL XR 200 MG TABLET	118	$27,787.63

Antipsychotic Utilization-Depression Diagnosis		
12/01/10 - 11/30/11		
Label Name	**Rx Num**	**Total Reimb**
SEROQUEL XR 300 MG TABLET	196	$82,210.03
SEROQUEL XR 400 MG TABLET	141	$87,914.10
SEROQUEL XR 50 MG TABLET	153	$29,690.43
THIORIDAZINE 100 MG TABLET	29	$1,067.90
THIORIDAZINE 50 MG TABLET	5	$104.97
TRIFLUOPERAZINE 1 MG TABLET	15	$450.96
TRIFLUOPERAZINE 10 MG TABLET	1	$46.75
TRIFLUOPERAZINE 2 MG TABLET	16	$443.86
TRIFLUOPERAZINE 5 MG TABLET	20	$522.05
ZYPREXA 10 MG TABLET	242	$136,786.05
ZYPREXA 15 MG TABLET	145	$139,346.96
ZYPREXA 2.5 MG TABLET	55	$16,400.05
ZYPREXA 20 MG TABLET	146	$175,099.62
ZYPREXA 5 MG TABLET	261	$106,531.61
ZYPREXA 7.5 MG TABLET	40	$22,267.62
ZYPREXA ZYDIS 10 MG TABLET	78	$42,210.58
ZYPREXA ZYDIS 15 MG TABLET	67	$55,040.97
ZYPREXA ZYDIS 20 MG TABLET	27	$27,556.67
ZYPREXA ZYDIS 5 MG TABLET	54	$21,011.35
1,760 recipients with depression diagnosis	**15,733**	**$5,127,931.68**

Antipsychotic Utilization-Exclude Psychosis Diagnosis (295, 296)		
12/01/10 - 11/30/11		
Label Name	**Rx Num**	**Total Reimb Amt**
ABILIFY 1 MG/ML SOLUTION	33	$3,610.66
ABILIFY 10 MG TABLET	225	$90,160.25
ABILIFY 15 MG TABLET	157	$51,687.10
ABILIFY 2 MG TABLET	334	$154,171.77
ABILIFY 20 MG TABLET	110	$64,876.21
ABILIFY 30 MG TABLET	24	$15,245.42
ABILIFY 5 MG TABLET	695	$282,526.51
ABILIFY DISCMELT 10 MG TABLET	13	$7,856.52
CHLORPROMAZINE 100 MG TABLET	1	$53.11
CHLORPROMAZINE 25 MG TABLET	1	$10.60
CHLORPROMAZINE 50 MG TABLET	3	$52.20
CLOZAPINE 100 MG TABLET	25	$1,230.27
CLOZAPINE 200 MG TABLET	18	$2,002.82
CLOZAPINE 50 MG TABLET	20	$1,195.25
FAZACLO 150 MG ODT	1	$61.62
GEODON 20 MG CAPSULE	50	$8,262.56
GEODON 40 MG CAPSULE	22	$3,015.36
GEODON 60 MG CAPSULE	35	$12,808.01
GEODON 80 MG CAPSULE	19	$1,824.54
HALOPERIDOL 0.5 MG TABLET	25	$251.23
HALOPERIDOL 1 MG TABLET	60	$517.41
HALOPERIDOL 2 MG TABLET	35	$375.73
HALOPERIDOL 5 MG TABLET	16	$279.10
INVEGA ER 3 MG TABLET	21	$9,183.42
INVEGA ER 6 MG TABLET	7	$2,781.96
INVEGA ER 9 MG TABLET	4	$2,762.86
INVEGA SUSTENNA 117 MG PREF SY	16	$12,738.60
INVEGA SUSTENNA 156 MG PREF SY	10	$10,686.56
INVEGA SUSTENNA 234 MG PREF SY	14	$22,441.33
LATUDA 40 MG TABLET	50	$22,156.92
LATUDA 80 MG TABLET	21	$9,013.32
OLANZAPINE 10 MG TABLET	3	$2,056.72
OLANZAPINE 2.5 MG TABLET	3	$670.77
OLANZAPINE 20 MG TABLET	5	$6,209.98
OLANZAPINE 5 MG TABLET	5	$2,332.85
OLANZAPINE 7.5 MG TABLET	1	$398.02
OLANZAPINE ODT 15 MG TABLET	3	$2,024.39
OLANZAPINE ODT 5 MG TABLET	1	$327.85
PERPHENAZINE 2 MG TABLET	2	$46.70
RISPERDAL 0.5 MG TABLET	1	$11.37
RISPERDAL 1 MG TABLET	24	$2,984.45
RISPERDAL 1 MG/ML SOLUTION	5	$105.05
RISPERDAL 3 MG TABLET	11	$3,584.41
RISPERIDONE 0.25 MG TABLET	668	$10,118.10
RISPERIDONE 0.5 MG ODT	15	$1,285.35
RISPERIDONE 0.5 MG TABLET	895	$13,182.53
RISPERIDONE 1 MG ODT	13	$1,750.66
RISPERIDONE 1 MG TABLET	836	$13,086.37
RISPERIDONE 1 MG/ML SOLUTION	246	$7,248.33
RISPERIDONE 2 MG ODT	3	$266.70
RISPERIDONE 2 MG TABLET	323	$6,019.21

Antipsychotic Utilization-Exclude Psychosis Diagnosis (295, 296)		
12/01/10 - 11/30/11		
Label Name	**Rx Num**	**Total Reimb Amt**
RISPERIDONE 3 MG TABLET	135	$2,141.42
RISPERIDONE 4 MG TABLET	44	$932.87
RISPERIDONE M-TAB 0.5 MG ODT	6	$446.91
RISPERIDONE M-TAB 1 MG ODT	3	$656.67
RISPERIDONE M-TAB 2 MG ODT	5	$901.94
RISPERIDONE M-TAB 3 MG ODT	11	$6,205.11
SAPHRIS 10 MG TAB SUBLINGUAL	10	$724.33
SAPHRIS 5 MG TABLET SUBLINGUAL	8	$152.73
SEROQUEL 100 MG TABLET	552	$99,620.76
SEROQUEL 200 MG TABLET	282	$90,968.96
SEROQUEL 25 MG TABLET	336	$46,233.89
SEROQUEL 300 MG TABLET	204	$101,881.91
SEROQUEL 400 MG TABLET	57	$15,062.83
SEROQUEL 50 MG TABLET	527	$98,505.29
SEROQUEL XR 150 MG TABLET	34	$8,131.80
SEROQUEL XR 200 MG TABLET	67	$16,784.80
SEROQUEL XR 300 MG TABLET	60	$19,968.92
SEROQUEL XR 400 MG TABLET	15	$4,291.51
SEROQUEL XR 50 MG TABLET	85	$14,321.65
THIORIDAZINE 10 MG TABLET	5	$92.37
THIORIDAZINE 100 MG TABLET	11	$143.45
THIORIDAZINE 50 MG TABLET	3	$34.32
ZYPREXA 10 MG TABLET	102	$55,147.40
ZYPREXA 10 MG VIAL	1	$44.14
ZYPREXA 15 MG TABLET	24	$12,515.75
ZYPREXA 2.5 MG TABLET	53	$14,083.39
ZYPREXA 20 MG TABLET	62	$73,593.98
ZYPREXA 5 MG TABLET	112	$46,322.17
ZYPREXA 7.5 MG TABLET	9	$3,002.13
ZYPREXA ZYDIS 10 MG TABLET	27	$14,067.81
ZYPREXA ZYDIS 15 MG TABLET	47	$35,818.17
ZYPREXA ZYDIS 20 MG TABLET	14	$14,446.84
ZYPREXA ZYDIS 5 MG TABLET	15	$5,520.12
993 recipients	**8054**	**$1,670,315.37**

327 Recipients with depression diagnosis (311) without psychosis diagnosis (295, 296)

Summary by Age		
Age	Recip Count	Rx Count
4	1	7
5	1	1
7	5	36
8	6	51
9	2	16
10	12	96
11	5	35
12	11	109
13	14	87
14	14	68
15	22	175
16	19	113
17	21	142
18	17	182
19	14	100
20	2	15
21	4	36
22	6	47
23	5	36
24	4	38
25	6	23
26	7	27
27	6	78
28	3	26
29	2	15
30	5	24
31	6	36
32	5	97
33	4	9
34	4	30
35	2	6
36	6	26
37	7	42
38	4	21
39	3	11
40	3	18
41	3	16
42	2	5
43	2	7
44	1	11
45	3	5
46	5	109
47	2	20
48	2	12
49	3	35
50	5	26
51	6	58
52	4	16
53	2	31

Summary by Age		
Age	Recip Count	Rx
54	4	38
55	4	58
56	2	25
57	4	41
58	1	4
59	3	37
60	4	50
62	1	28
63	2	38
64	2	5
65	1	2
66	1	1

Top Diagnoses for recipients with depression diagnosis (311) and no psychosis diagnosis (295, 296)

DX Code	DX Description	Count
31401	ATTENTION DEFICIT DIS W HYPERACT	2,018
31381	OPPOSITIONAL DEFIANT DISORDER	1,087
V5869	ENCOUNTER LONG TERM USE OTH DRUGS	854
78900	ABDOMINAL PAIN UNS SITE	820
25000	DIABETES UNCOMPL TYPE II	618
3094	ADJUST DIS EMOT/CONDUCT DISTUR	587
4019	UNSPECIFIED ESSENTIAL HYPERTENSION	537
7999	OTH UNKNOWN/UNS MORBIDITY/MORTALITY	489
7242	LUMBAGO	483
3004	DYSTHYMIC DISORDER	469
7840	HEADACHE	464
5363	GASTROPARESIS	440
3671	MYOPIA	430
30000	ANXIETY STATE UNSPECIFIED	412
78702	NAUSEA ALONE	409
V5883	ENCTR THERAP DRUG MONITORING	404
462	ACUTE PHARYNGITIS	402
25060	DIABETES NEURO MANIF TYPE II	346
30981	POSTTRAUMATIC STRESS DISORDER	340
78079	OTHER MALAISE AND FATIGUE	301
486	PNEUMONIA ORGANISM UNSPECIFIED	287
V0481	VACCINE FOR INFLUENZA	264
20190	UNS HODGKIN'S DISEASE UNS EXTRANOD	261
31230	UNS IMPULSE CONTROL DISORDER	252
3129	UNS DISTURBANCE CONDUCT	248
7245	BACKACHE UNSPECIFIED	248
71941	PAIN IN JOINT SHOULDER	241
27651	DEHYDRATION	235
7295	PAIN IN LIMB	221
3128	OTHER CONDUCT DISTURBANCE	221
7862	COUGH	221
31282	CONDUCT DISORDER ADOLESCENT ONSET	219
2449	UNS HYPOTHYROIDISM	218
5990	URINARY TRACT INFECTION UNSPEC	216
7231	CERVICALGIA	215
78701	NAUSEA WITH VOMITING	214
78791	DIARRHEA	208
30002	GENERALIZED ANXIETY DISORDER	204
83920	DISLOCATION LUMBAR VERT CLOSED	200
83921	DISLOCATION THORACIC VERT CLOSED	193
78650	UNSPEC CHEST PAIN	162
78060	FEVER UNSPECIFIED	161

South Dakota Medicaid
P&T Commitee
Low Dose Quetiapine
March 2, 2012

In fourth quarter 2011, quetiapine was the fourth leading drug based on claims cost. There were 1,526 prescriptions reported at a cost of $493,074. This averages out to approximately $323 per prescription.

Quetiapine is indicated for use in the treatment of schizophrenia and bipolar disorder; however, it is commonly used off-label as a treatment for insomnia. When using quetiapine for patients with schizophrenia or bipolar disorder, the doses range from 300-800mg/day. In patients being treated for insomnia, providers generally use a much lower dose, no more than 100mg/day.

At the December meeting, the P&T committee requested information about the number of patients using low-dose quetiapine. This report includes quetiapine 25mg and 50mg, in which patients were given 60 tablets per month or less, thereby keeping the total dose to 100mg/day or less.

Low Dose Quetiapine 12/01/10 – 11/30/11			
	Number of Prescriptions	Total Paid Amount	Unique Number of Recipients
All Seroquel IR utilization	6,144	$1,956,894.80	835
All Patients with 60 tablets or less	1,879	$293,583.02	429
Patients without a bipolar (296) or schizophrenia (295) diagnosis with 60 tablets or less	797	$119,611.98	168

Summary by Age of the 168 recipients taking 60 tablets or less of quetiapine without a bipolar or schizophrenia diagnosis

3-10	21
11-20	65
21-30	19
31-40	21
41-50	13
51-60	21
60 and above	8

Top Diagnoses for recipients without a bipolar (296) or schizophrenia (295) diagnosis taking fewer than 60 tablets per month 01/01/2010-12/31/2011

DX Code	DX Description	Count
31401	ATTENTION DEFICIT DIS W HYPERACT	891
31381	OPPOSITIONAL DEFIANT DISORDER	419
311	DEPRESSIVE DISORDER OTHER	396
V5869	ENCOUNTER LONG TERM USE OTH DRUGS	281
4019	UNSPECIFIED ESSENTIAL HYPERTENSION	258
30000	ANXIETY STATE UNSPECIFIED	221
83920	DISLOCATION LUMBAR VERT CLOSED	221
78900	ABDOMINAL PAIN UNS SITE	212
3671	MYOPIA	204
25000	DIABETES UNCOMPL TYPE II	194
7242	LUMBAGO	190
462	ACUTE PHARYNGITIS	187
3004	DYSTHYMIC DISORDER	181
30002	GENERALIZED ANXIETY DISORDER	177
78039	OTHER CONVULSIONS	166
83921	DISLOCATION THORACIC VERT CLOSED	164
486	PNEUMONIA ORGANISM UNSPECIFIED	164
30981	POSTTRAUMATIC STRESS DISORDER	164
3129	UNS DISTURBANCE CONDUCT	154
7999	OTH UNKNOWN/UNS MORBIDITY/MORTALITY	150
83908	DISLOCATION MULT CERV VERT CLOSED	136
51881	RESPIRATORY FAILURE	127
7840	HEADACHE	124
7295	PAIN IN LIMB	124
V0481	VACCINE FOR INFLUENZA	122
29900	AUTISTIC DISORDER CURR/ACTIVE	121
3149	UNSPEC HYPERKINETIC SYNDROME	118
78079	OTHER MALAISE AND FATIGUE	117
79902	HYPOXEMIA	116
V5883	ENCTR THERAP DRUG MONITORING	114
7100	SYSTEMIC LUPUS ERYTHEMATOSUS	111
31282	CONDUCT DISORDER ADOLESCENT ONSET	110
7245	BACKACHE UNSPECIFIED	108
7140	RHEUMATOID ARTHRITIS	101
4321	SUBDURAL HEMORRHAGE	99
31389	OTH EMOTIONAL DISTURBANCE CHILDHOOD	96
3051	TOBACCO USE DISORDER	95
V700	ROUTINE MEDICAL EXAM HEALTH FACIL	92
7862	COUGH	91
2724	OTH/UNS HYPERLIPIDEMIA	91
30500	ALCOHOL ABUSE UNSPEC	90

Top Diagnoses for recipients without a bipolar (296) or schizophrenia (295) diagnosis taking fewer than 60 tablets per month
01/01/2010-12/31/2011

3094	ADJUST DIS EMOT/CONDUCT DISTUR	90
2449	UNS HYPOTHYROIDISM	87
33829	OTHER CHRONIC PAIN	85
5990	URINARY TRACT INFECTION UNSPEC	84
30520	CANNABIS ABUSE UNS	83
78791	DIARRHEA	81
7231	CERVICALGIA	76
7291	UNS MYALGIA/MYOSITIS	76
78650	UNSPEC CHEST PAIN	76

South Dakota Department of Social Services
P&T Meeting
Lidoderm® Review

I. Overview

Lidocaine is an amide-type local anesthetic agent and is suggested to stabilize neuronal membranes by inhibiting the ionic fluxes required for the initiation and conduction of impulses. The penetration of lidocaine into intact skin after application is sufficient to produce an analgesic effect, but less than the amount necessary to produce a complete sensory block.

II. Indication

Lidoderm is indicated for relief of pain associated with post-herpetic neuralgia. It should be applied only to intact skin.

III. Warnings

- Even a used Lidoderm patch contains a large amount of lidocaine (at least 665mg). The potential exists for a small child or pet to suffer serious adverse effects from chewing or ingesting a new or used patch. It is important for patients to store and dispose of Lidoderm out of the reach of children, pets and others.

- Excessive dosing by applying Lidoderm to larger areas or for longer than the recommended wearing time should result in increased absorption of lidocaine and high blood concentrations, leading to serious adverse effects. Lidocaine toxicity could be expected at lidocaine blood concentrations above 5 *u*g/mL. The blood concentration of lidocaine is determined by the rate of systemic absorption and elimination. Longer duration of application, application of more than the recommended number of patches, smaller patients, or impaired elimination may all contribute to increasing the blood concentration of lidocaine.

IV. Precautions

- Patients with severe hepatic disease are at greater risk of developing toxic blood concentrations of lidocaine, because of their inability to metabolize lidocaine normally.

- Lidoderm should be used with caution in patients with a history of drug sensitivities, especially if the etiologic agent is uncertain.

- Application to broken or inflamed skin, although not tested, may result in higher blood concentrations of lidocaine from increased absorption. Lidoderm is only recommended for use on intact skin.

- Placement of external heat sources, such as heating pads or electric blankets, over Lidoderm patches is not recommended as this has not been evaluated and may increase plasma lidocaine levels.

- The contact of Lidoderm with eyes, although not studied, should be avoided based on the findings of severe eye irritation with the use of similar products in animals. If eye contact occurs, immediately wash out the eye with water or saline and protect the eye until sensation returns.

V. Drug Interactions

- Lidoderm should be used with caution in patients receiving Class I antiarrhythmic drugs (such as tocainide and mexiletine) since the toxic effects are additive and potentially synergistic.

- When Lidoderm is used concomitantly with other products containing local anesthetic agents, the amount absorbed from all formulations must be considered.

VI. Adverse Reactions

- During or immediately after treatment with Lidoderm, the skin at the site of application may develop blisters, bruising, burning sensation, depigmentation, dermatitis, discoloration, edema, erythema, exfoliation, irritation, papules, petechiae, pruritus, vesicles, or may be the locus of abnormal sensation. These reactions are generally mild and transient, resolving spontaneously within a few minutes to hours.

- Allergic and anaphylactoid reactions associated with lidocaine, although rare, can occur. They are characterized by angioedema, bronchospasm, dermatitis, dyspnea, hypersensitivity, laryngospasm, pruritus, shock, and urticaria.

- Systemic adverse reactions following appropriate use of Lidoderm are unlikely, due to the small dose absorbed.

VII. Dosage and Administration

- Apply Lidoderm to intact skin to cover the most painful area. Apply up to three patches, only once for up to 12 hours within a 24-hour period. Patches may be cut into smaller sizes with scissors prior to removal of the release liner. Clothing may be worn over the area of application. Smaller areas of treatment are recommended in a debilitated patient, or a patient with impaired elimination.

VIII. Utilization

Lidoderm Utilization 12/01/10 – 11/30/11		
Label Name	**Rx Num**	**Total Reimb Amt**
Lidoderm (310 recip)	795	$237,301.06

References

1. Lidoderm® [prescribing information]. Chadds Ford, PA. Endo Pharmaceuticals., Inc.; March 2010.

South Dakota Department of Social Services
P&T Meeting
Brilinta® Review

I. Overview

Brilinta (ticagrelor) is a $P2Y_{12}$ platelet inhibitor indicated to reduce the rate of thrombotic cardiovascular events in patients with acute coronary syndrome (ACS).

II. Dosage and Administration

- Initiate treatment with 180mg (two 90mg tablets) oral loading dose.
- Continue treatment with 90mg twice daily.
- After the initial loading dose of aspirin (usually 325mg), use Brilinta with a daily maintenance dose of aspirin of 75-100mg.

III. Contraindications

- History of intracranial hemorrhage.
- Active pathological bleeding.
- Severe hepatic impairment.

IV. Warnings and Precautions

- Like other antiplatelet agents, Brilinta increases the risk of bleeding.
- In PLATO, use of Brilinta with maintenance doses of aspirin above 100mg decreased the effectiveness of Brilinta.
- Moderate Hepatic Impairment-consider the risks and benefits of treatment, noting the probable increase in exposure to ticagrelor.
- Dyspnea was reported more frequently with Brilinta than with clopidogrel. Dyspnea resulting from Brilinta is self-limiting. Rule out other causes.
- Premature discontinuation increases the risk of myocardial infarction, stent thrombosis, and death.

V. Adverse Reactions

Most common adverse reactions are bleeding 12% and dyspnea 14%.

VI. Drug Interactions

- Avoid use with strong CYP3A inhibitors or CYP3A inducers.
- Patients receiving more than 40mg per day of simvastatin or lovastatin may be at increased risk of statin-related adverse effects.
- Monitor digoxin levels with initiation of or any change in Brilinta.

VII. Utilization

Platelet Aggregation Inhibitors Utilization		
12/01/10 – 11/30/11		
Label Name	**Rx Num**	**Total Reimb Amt**
Cilostazol 100mg	35	$508.77
Cilostazol 50mg	17	$361.56
Effient 10mg	51	$8,824.47
Effient 5mg	1	$185.74
Plavix 75mg	674	$118,191.01
225 recipients	**1447**	**$247,559.74**

References

1. Brilinta® [prescribing information]. Wilmington, DE. AstraZeneca LP; July 2011.

South Dakota Department of Social Services
P&T Meeting
Lorzone™ Review

I. Overview

Lorzone is indicated as an adjunct to rest, physical therapy, and other measures, for the relief of discomfort associated with acute, painful musculoskeletal conditions. The mode of action of this drug has not been clearly identified, but may be related to its sedative properties. Chlorzoxazone does not directly relax tense skeletal muscles.

II. Pharmacology

Chlorzoxazone is a centrally-acting agent for painful musculoskeletal conditions. Data available from animal experiments as well as human studies indicate that chlorzoxazone acts primarily at the level of the spinal cord and subcortical areas of the brain where it inhibits multisynaptic reflex arcs involved in producing and maintaining skeletal muscle spasms of varied etiology. The clinical result is a reduction of the skeletal muscle spasm with relief of pain and increased mobility of the involved muscles. Blood levels of chlorzoxazone can be detected in people during the first 30 minutes and peak levels may be reached, in the majority of the subjects, in about 1 to 2 hours after oral administration of chlorzoxazone. Chlorzoxazone is rapidly metabolized and is excreted in the urine, primarily in a conjugated form as the glucuronide. Less than one percent of a dose of chlorzoxazone is excreted unchanged in the urine in 24 hours.

III. Warnings/Precautions

1. Serious (including fatal) hepatocellular toxicity has been reported rarely in patients receiving chlorzoxazone. The mechanism is unknown but appears to be idiosyncratic and unpredictable. Factors predisposing patients to this rare event are not known. Patients should be instructed to report early signs and/ or symptoms of hepatoxicity such as fever, rash, anorexia, nausea, vomiting, fatigue, right upper quadrant pain, dark urine, or jaundice. Lorzone™ should be discontinued immediately and a physician consulted if any of these signs or symptoms develop. Lorzone™ use should also be discontinued if a patient develops abnormal liver enzymes (e.g., AST, ALT, alkaline phosphates and bilirubin).
2. The concomitant use of alcohol or other central nervous system depressants may have an additive effect.
3. The safe use of Lorzone has not been established with respect to the possible adverse effects upon fetal development. Therefore, it should be used in women of childbearing potential only when, in the judgement of the physician, the potential benefits outweigh the possible risks.
4. If sensitivity reactions occur such as urticaria, redness, or itching of the skin, the drug should be stopped.

5. If any symptoms suggestive of liver dysfunction are observed, the drug should be discontinued.

IV. Adverse Reactions

Chlorzoxazone-containing products are usually well tolerated. It is possible in rare instances that chlorzoxazone may have been associated with gastrointestinal bleeding. Drowsiness, dizziness, light- headedness, malaise, or overstimulation may be noted by an occasional patient. Rarely, allergic-type skin rashes, petechiae, or ecchymoses may develop during treatment. Angioneurotic edema or anaphylactic reactions are extremely rare. There is no evidence that the drug will cause renal damage. Rarely, a patient may note discoloration of the urine resulting from a phenolic metabolite of chlorzoxazone. This finding is of no known clinical significance.

V. Dosage and Administration

Lorzone 375mg – one tablet three or four times daily. If adequate response is not obtained with this dose, the 375mg tablets may be increased to two tablets (750mg) three or four times daily. As improvement occurs, dosage can usually be reduced.

Lorzone 750mg – 2/3 tablet (500mg) three or four times daily. If adequate response is not obtained with this dose, it may be increased to one tablet (750mg) three or four times daily. As improvement occurs, dosage can usually be reduced.

VI. Drug Interactions

CNS Agents-the concomitant use of alcohol or other CNS depressants may have an additive effect.

References

1. Lorzone[TM] [prescribing information]. Sayreville, NJ. Vertical Pharmaceuticals., Inc.; October 2010.