South Dakota Department of Social Services

Medicaid P&T Committee Meeting

March 8, 2013

DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES
700 Governors Drive
Pierre, South Dakota 57501-2291
(605) 773-3495
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SOUTH DAKOTA
MEDICAID P&T COMMITTEE MEETING
AGENDA

Friday, March 8, 2013
1:00 – 3:00 PM
Hilton Garden Inn
5300 South Grand Circle
Sioux Falls, SD

Call to Order

Approval of Minutes of Previous Meeting

Prior Authorization Update

Review of Top 15 Therapeutic Categories/Top 25 Drugs

Old Business
- **Genitourinary Smooth Muscle Relaxants**
- **Xeljanz**
- **Review PA forms and criteria**

New Business
- **Medications used to treat ADHD**
- **Opiate Agonists**
- **Juxtapid**
- **Gattex**

Oral Presentations and Comments by Manufacturers' Representatives

Next Meeting Date/Adjournment

Minutes of the December 14, 2012
Pharmacy & Therapeutics (P&T) Committee Meeting
SD Department of Social Services, Medical Services Division

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

Members absent
Rick Holm, MD; Michelle Baack, MD

DSS staff present
Mike Jockheck, RPh; Kirby Stone, Director of Medical Services

HID staff present
Candace Rieth, PharmD

Administrative Business
The P&T meeting was called to order by D. Darger at approximately 1:00pm. The minutes of the September 14, 2012 meeting were presented. B. Ladwig made a motion to approve. D. Farver 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 2012. There were a total of 5,557 PAs processed in the month of October, with 99.8% of those requests responded to in less than 8 hours. There were 4,408 (79%) requests received electronically and 1,149 (21%) 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 07/01/2012 – 09/30/2012. The top five classes were antipsychotics, cerebral stimulants, amphetamines, central nervous system agents misc., and corticosteroids (respiratory tract). The top 15 therapeutic classes make up 40.35% 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 12.03% of total claims. After reviewing the reports, the committee requested that ADHD and Opiates be discussed at the next meeting.

Nasal Steroids for Allergic Rhinitis
At the September meeting, the committee reviewed utilization for nasal steroids. A motion was made to develop a PA form and criteria for the nasal steroids used to treat allergic rhinitis. C. Rieth reviewed the prior authorization form. A motion was made by B. Ladwig to approve the PA form. J. Engelbrecht seconded the motion. L. McDermott, representing Sunovion, spoke regarding Zetonna. The motion was approved.

Antiretrovirals Review
C. Rieth reviewed utilization and trend summary information for the antiretrovirals. This topic was tabled.

Genitourinary Smooth Muscle Relaxants Review
C. Rieth reviewed genitourinary smooth muscle relaxant (GSM) clinical information and utilization including the age distribution of recipients. A motion was made by J. Engelbrecht to develop a prior authorization form and criteria for GSMs. T. Soundy seconded the motion. T. Ahlers, representing Pfizer, spoke regarding Toviaz. The motion was approved.

Rayos Review
C. Rieth reviewed Rayos clinical information. A motion was made by B. Ladwig to place Rayos on prior authorization. J. Engelbrecht seconded the motion. There was no public comment. The motion was approved.

Xeljanz Review
C. Rieth reviewed Xeljanz clinical information. A motion was made by J. Engelbrecht to develop a prior authorization and criteria for Xeljanz. K. Oehlke seconded the motion. V. Castellano, representing Pfizer, spoke regarding Xeljanz. The motion was approved.

Aubagio Review
C. Rieth reviewed Aubagio clinical information. A motion was made by B. Ladwig to place Aubagio on prior authorization. K. Oehlke seconded the motion. There was no public comment. The motion was approved.

Truvada for pre-exposure HIV prophylaxis
C. Rieth reviewed Truvada clinical information. D. Darger suggested that he could consult with HIV experts regarding the importance of managing Truvada. This information will be reviewed at a future meeting.

Xifaxan Review
C. Rieth reviewed Xifaxan clinical information. A motion was made by D. Farver to place Xifaxan on prior authorization. T. Soundy seconded the motion. There was no public comment. The motion was approved.

Relistor Review
C. Rieth reviewed Relistor clinical information. A motion was made by B. Ladwig to place Relistor on prior authorization. D. Farver seconded the motion. There was no public comment. The motion was approved.

The next meeting date is scheduled for March 8, 2013. A motion was made by B. Ladwig to adjourn the SD Medicaid P&T meeting. D. Farver seconded the motion. Motion passed unanimously and the meeting was adjourned.

HEALTH INFORMATION DESIGNS

South Dakota Medicaid
Monthly Prior Authorization Report
January 1, 2013 – January 31, 2013

Time Ratio

Total PAs	Response Under 8 Hours	Response Over 8 Hours	% Under 8 Hours	% Over 8 Hours
3,198	3,163	35	98.91%	1.09%

By Form Type

Form Type	Description	Approve	Deny
ADP	Antidepressant	150	207
ALT	Altabax	2	2
AMB	Ambien CR	5	16
ANF	Anti-Infectives (anti-biotic)	0	2
ANT	Antihistamines	11	62
APS	Antipsychotic	268	463
ARB	ARBS	14	19
COA	Oral Anticoagulants	7	5
CYA	Cyanocobalamin	1	0
DAW	Dispense As Written	13	55
GRH	Growth Hormone	4	3
HEP	Hepatitis Meds	1	1
HLM	Head Lice Medication	7	71
LID	Lidoderm	1	75
MAX	Max Units Override	56	1117
NAR	Name Brand Narcotics	3	2
NUC	Opioids	5	11
ONF	Onfi	12	48
OPH	Ophthalmic Antihistamines	0	8
PPI	Proton Pump Inhibitors	39	101
SMR	Skeletal Muscle Relaxants	0	1
STI	Stimulants	5	21
SUB	Suboxone/Subutex	4	1
TIM	Targeted Immune Modulators	7	15
TOP	Topical Acne Agents	20	167
TRP	Triptans	19	48
ULT	Ultram ER	4	17
XOI	Xanthine Oxidase Inhibitor	1	0
XOL	Xolair	1	0
Totals		660	2538

HEALTH INFORMATION DESIGNS

South Dakota Medicaid
Monthly Prior Authorization Report
January 1, 2013 – January 31, 2013

By Request Type

01/01/13 - 01/31/13	# of	Electronic Requests		Faxed Requests	
	Requests	#	%	#	%
Prior Authorizations:					
Antidepressant	357	247	69%	110	31%
Altabax	4	2	50%	2	50%
Ambien CR	21	18	86%	3	14%
Anti-Infectives (anti-biotic)	2	2	100%	0	0%
Antihistamines	73	54	74%	19	26%
Antipsychotic	731	493	67%	238	33%
ARBS	33	23	70%	10	30%
Oral Anticoagulants	12	10	83%	2	17%
Cyanocobalamin	1	1	100%	0	0%
Dispense As Written	68	46	68%	22	32%
Growth Hormone	7	2	29%	5	71%
Hepatitis Meds	2	0	0%	2	100%
Head Lice Medication	78	50	64%	28	36%
Lidoderm	76	61	80%	15	20%
Max Units Override	1173	1104	94%	69	6%
Name Brand Narcotics	5	2	40%	3	60%
Opioids	16	10	63%	6	38%
Onfi	60	38	63%	22	37%
Ophthalmic Antihistamines	8	7	88%	1	13%
Proton Pump Inhibitors	140	106	76%	34	24%
Skeletal Muscle Relaxants	1	1	100%	0	0%
Stimulants	26	19	73%	7	27%
Suboxone/Subutex	5	0	0%	5	100%
Targeted Immune Modulators	22	15	68%	7	32%
Topical Acne Agents	187	145	78%	42	22%
Triptans	67	53	79%	14	21%
Ultram ER	21	18	86%	3	14%
Xanthine Oxidase Inhibitor	1	0	0%	1	100%
Xolair	1	0	0%	1	100%
Totals	3198	2527	79%	671	21%

South Dakota Medicaid
Monthly Prior Authorization Report
January 1, 2013 – January 31, 2013

Electronic PAs (unique)

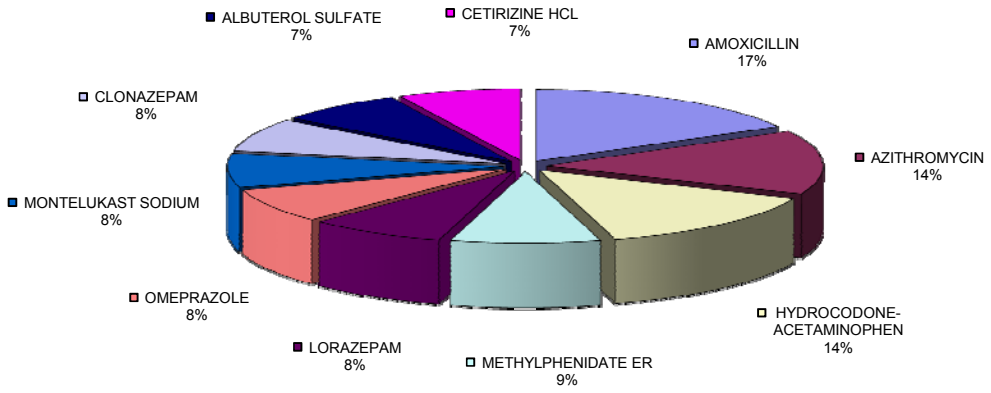
01/01/13 - 01/31/13	# Unique Approved	# Unique Denied	# Unique Incomplete	Unique Total	Approval %	Total Transactions
Prior Authorizations:						
Antidepressant	84	157	0	241	34.90%	247
Altabax	1	1	0	2	50.00%	2
Ambien CR	5	11	0	16	31.30%	18
Anti-Infectives (anti-biotic)	0	2	0	2	0.00%	2
Antihistamines	11	42	0	53	20.80%	54
Antipsychotic	117	350	0	467	25.10%	493
ARBS	7	13	0	20	35.00%	23
Oral Anticoagulants	6	4	0	10	60.00%	10
Cyanocobalamin	1	0	0	1	100.00%	1
Dispense As Written	0	40	0	40	0.00%	46
Growth Hormone	0	2	0	2	0.00%	2
Head Lice Medication	0	50	0	50	0.00%	50
Lidoderm	0	60	0	60	0.00%	61
Max Units Override	16	1037	0	1053	1.50%	1104
Name Brand Narcotics	0	2	0	2	0.00%	2
Opioids	3	6	0	9	33.30%	10
Onfi	0	37	0	37	0.00%	38
Ophthalmic Antihistamines	0	7	0	7	0.00%	7
Proton Pump Inhibitors	30	71	0	101	29.70%	106
Skeletal Muscle Relaxants	0	1	0	1	0.00%	1
Stimulants	0	19	0	19	0.00%	19
Targeted Immune Modulators	2	13	0	15	13.30%	15
Topical Acne Agents	7	136	0	143	4.90%	145
Triptans	13	39	0	52	25.00%	53
Ultram ER	2	14	0	16	12.50%	18
Totals	305	2114	0	2419	12.60%	2527

TOP 25 DRUGS BASED ON NUMBER OF CLAIMS FROM 10/01/2012 - 12/31/2012

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
AMOXICILLIN	PENICILLINS	8,131	$ 78,734.68	$ 9.68	3.67%
AZITHROMYCIN	MACROLIDES	6,923	$ 107,762.58	$ 15.57	3.12%
HYDROCODONE-ACETAMINOPHEN	OPIATE AGONISTS	6,778	$ 87,897.12	$ 12.97	3.06%
METHYLPHENIDATE ER	RESPIRATORY AND CNS STIMULANTS	4,201	$ 701,716.13	$ 167.04	1.89%
LORAZEPAM	BENZODIAZEPINES (ANXIOLYTIC,SEDATIV/HYP)	3,865	$ 27,619.20	$ 7.15	1.74%
OMEPRAZOLE	PROTON-PUMP INHIBITORS	3,722	$ 48,325.61	$ 12.98	1.68%
MONTELUKAST SODIUM	LEUKOTRIENE MODIFIERS	3,673	$ 75,957.64	$ 20.68	1.66%
CLONAZEPAM	BENZODIAZEPINES (ANTICONVULSANTS)	3,610	$ 26,537.89	$ 7.35	1.63%
ALBUTEROL SULFATE	BETA-ADRENERGIC AGONISTS	3,532	$ 63,693.98	$ 18.03	1.59%
CETIRIZINE HCL	SECOND GENERATION ANTIHISTAMINES	3,440	$ 32,802.71	$ 9.54	1.55%
TRAMADOL HCL	OPIATE AGONISTS	3,018	$ 32,841.51	$ 10.88	1.36%
FLUOXETINE HCL	ANTIDEPRESSANTS	2,878	$ 24,862.63	$ 8.64	1.30%
VYVANSE	AMPHETAMINES	2,784	$ 426,096.99	$ 153.05	1.26%
LEVOTHYROXINE SODIUM	THYROID AGENTS	2,558	$ 21,062.75	$ 8.23	1.15%
SERTRALINE HCL	ANTIDEPRESSANTS	2,462	$ 20,143.68	$ 8.18	1.11%
DEXTROAMPHETAMINE-AMPHETAMINE	AMPHETAMINES	2,442	$ 343,796.16	$ 140.78	1.10%
CEFDINIR	CEPHALOSPORINS	2,404	$ 97,241.23	$ 40.45	1.08%
TRAZODONE HCL	ANTIDEPRESSANTS	2,286	$ 13,402.67	$ 5.86	1.03%
SULFAMETHOXAZOLE-TRIMETHOPRIM	SULFONAMIDES (SYSTEMIC)	2,229	$ 18,839.39	$ 8.45	1.01%
AMOX TR-POTASSIUM CLAVULANATE	PENICILLINS	2,228	$ 59,577.73	$ 26.74	1.00%
LISINOPRIL	ANGIOTENSIN-CONVERTING ENZYME INHIBITORS	2,075	$ 11,426.40	$ 5.51	0.94%
LORATADINE	SECOND GENERATION ANTIHISTAMINES	2,066	$ 12,962.78	$ 6.27	0.93%
VENTOLIN HFA	BETA-ADRENERGIC AGONISTS	2,050	$ 86,942.13	$ 42.41	0.92%
CEPHALEXIN	CEPHALOSPORINS	1,892	$ 20,893.33	$ 11.04	0.85%
INTUNIV	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	1,886	$ 335,531.30	$ 177.91	0.85%
TOTAL TOP 25		83,133	$ 2,776,668.22	$ 33.40	37.48%

Total Rx Claims From 10/01/2012 - 12/31/2012	221,780

Top 10 Drugs
Based on Number of Claims

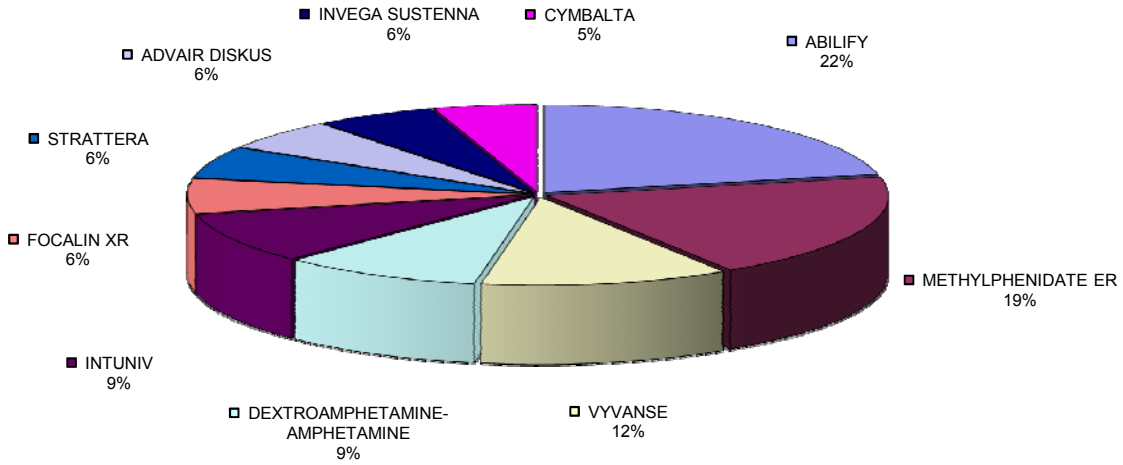


TOP 25 DRUGS BASED ON TOTAL CLAIMS COST FROM 10/01/2012 - 12/31/2012

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
ABILIFY	ANTIPSYCHOTIC AGENTS	1,466	$ 782,609.69	$ 533.84	0.66%
METHYLPHENIDATE ER	RESPIRATORY AND CNS STIMULANTS	4,201	$ 701,716.13	$ 167.04	1.89%
VYVANSE	AMPHETAMINES	2,784	$ 426,096.99	$ 153.05	1.26%
DEXTROAMPHETAMINE-AMPHETA	AMPHETAMINES	2,442	$ 343,796.16	$ 140.78	1.10%
INTUNIV	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	1,886	$ 335,531.30	$ 177.91	0.85%
FOCALIN XR	RESPIRATORY AND CNS STIMULANTS	1,268	$ 229,370.54	$ 180.89	0.57%
STRATTERA	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	1,076	$ 211,248.47	$ 196.33	0.49%
ADVAIR DISKUS	CORTICOSTEROIDS (RESPIRATORY TRACT)	849	$ 206,010.70	$ 242.65	0.38%
INVEGA SUSTENNA	ANTIPSYCHOTIC AGENTS	152	$ 205,587.40	$ 1,352.55	0.07%
CYMBALTA	ANTIDEPRESSANTS	814	$ 177,195.81	$ 217.69	0.37%
OXYCONTIN	OPIATE AGONISTS	482	$ 163,057.29	$ 338.29	0.22%
PREVACID	PROTON-PUMP INHIBITORS	782	$ 162,379.97	$ 207.65	0.35%
PULMOZYME	ENZYMES	56	$ 145,965.05	$ 2,606.52	0.03%
HUMIRA	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	65	$ 140,904.61	$ 2,167.76	0.03%
LYRICA	ANTICONVULSANTS, MISCELLANEOUS	636	$ 140,398.79	$ 220.75	0.29%
FLOVENT HFA	CORTICOSTEROIDS (RESPIRATORY TRACT)	875	$ 125,444.51	$ 143.37	0.39%
COPAXONE	BIOLOGIC RESPONSE MODIFIERS	27	$ 117,140.42	$ 4,338.53	0.01%
TOBI	AMINOGLYCOSIDES	22	$ 116,222.51	$ 5,282.84	0.01%
NEXIUM	PROTON-PUMP INHIBITORS	504	$ 112,211.17	$ 222.64	0.23%
TAMIFLU	NEURAMINIDASE INHIBITORS	831	$ 111,925.47	$ 134.69	0.37%
XENAZINE	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	16	$ 110,202.81	$ 6,887.68	0.01%
BUDESONIDE	CORTICOSTEROIDS (RESPIRATORY TRACT)	448	$ 108,754.49	$ 242.76	0.20%
AZITHROMYCIN	MACROLIDES	6,923	$ 107,762.58	$ 15.57	3.12%
HELIXATE FS	HEMOSTATICS	4	$ 106,880.83	$ 26,720.21	0.00%
ONE TOUCH ULTRA TEST STRIPS	DIABETES MELLITUS	659	$ 104,858.28	$ 159.12	0.30%
TOTAL TOP 25		29,268	$ 5,493,271.97	$ 187.69	13.20%

Total Rx Claims From 10/01/2012 - 12/31/2012	221,780

Top 10 Drugs
Based on Total Claims Cost



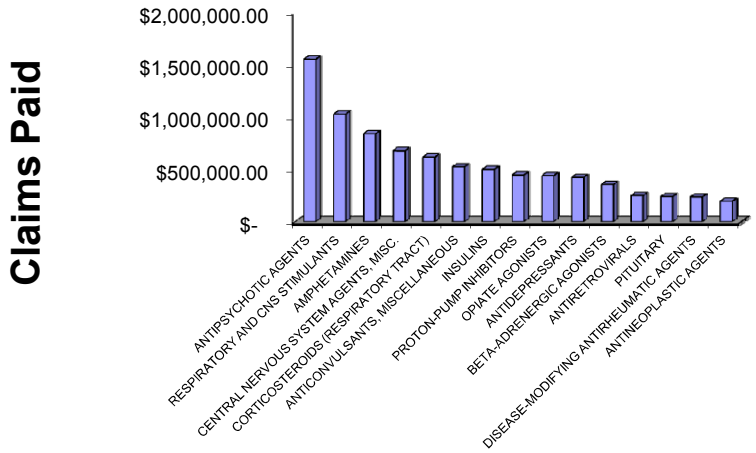
SOUTH DAKOTA MEDICAID
Cost Management Analysis

TOP 15 THERAPEUTIC CLASSES BY TOTAL COST OF CLAIMS FROM 10/01/2012 - 12/31/2012

AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
ANTIPSYCHOTIC AGENTS	7,185	$ 1,554,353.65	$ 216.33	3.24%
RESPIRATORY AND CNS STIMULANTS	6,834	$ 1,028,659.46	$ 150.52	3.08%
AMPHETAMINES	6,149	$ 841,381.40	$ 136.83	2.77%
CENTRAL NERVOUS SYSTEM AGENTS, MISC.	3,021	$ 680,247.20	$ 225.17	1.36%
CORTICOSTEROIDS (RESPIRATORY TRACT)	3,047	$ 619,649.86	$ 203.36	1.37%
ANTICONVULSANTS, MISCELLANEOUS	8,305	$ 526,362.03	$ 63.38	3.74%
INSULINS	2,121	$ 502,041.72	$ 236.70	0.96%
PROTON-PUMP INHIBITORS	6,341	$ 446,821.07	$ 70.47	2.86%
OPIATE AGONISTS	14,906	$ 440,562.12	$ 29.56	6.72%
ANTIDEPRESSANTS	16,358	$ 423,075.07	$ 25.86	7.38%
BETA-ADRENERGIC AGONISTS	7,916	$ 357,005.51	$ 45.10	3.57%
ANTIRETROVIRALS	257	$ 250,183.31	$ 973.48	0.12%
PITUITARY	533	$ 240,062.54	$ 450.40	0.24%
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	130	$ 237,510.12	$ 1,827.00	0.06%
ANTINEOPLASTIC AGENTS	477	$ 196,400.10	$ 411.74	0.22%
TOTAL TOP 15	83,580	$ 8,344,315.16	$ 99.84	37.69%

Total Rx Claims From 10/01/2012 - 12/31/2012	221,780

Top 15 Therapeutic Classes
Based on Total Cost of Claims



Genitourinary Smooth Muscle Relaxants (GSM)
PRIOR AUTHORIZATION

SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

- Patient must have an FDA approved indication for the medication requested.
- Patient must try oxybutynin or oxybutynin ER.

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage:	Diagnosis for this request:
□ **Enablex** □ **Detrol LA** □ **Toviaz** □ **Gelnique** □ **Myrbetriq** □ **Oxytrol** □ **Detrol** □ **Sanctura** □ **Vesicare** □ **Sanctura XR**	Failed therapy (Drug and Dose): Start Date: End Date:
PHYSICIAN SIGNATURE:	DATE:

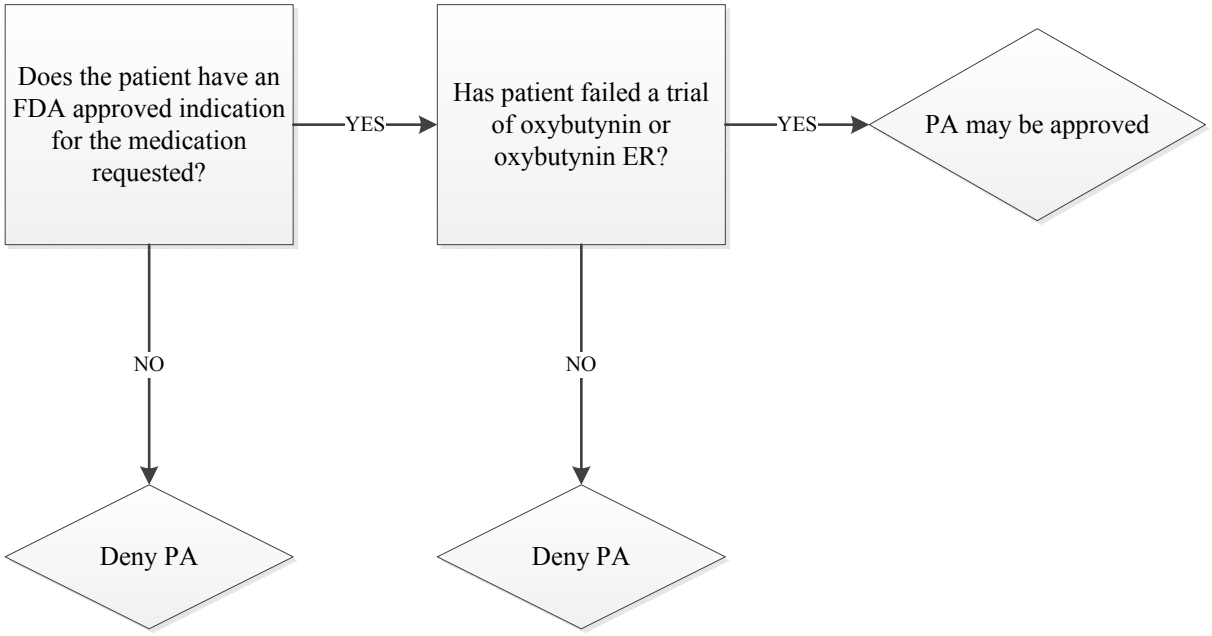
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

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



XELJANZ
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

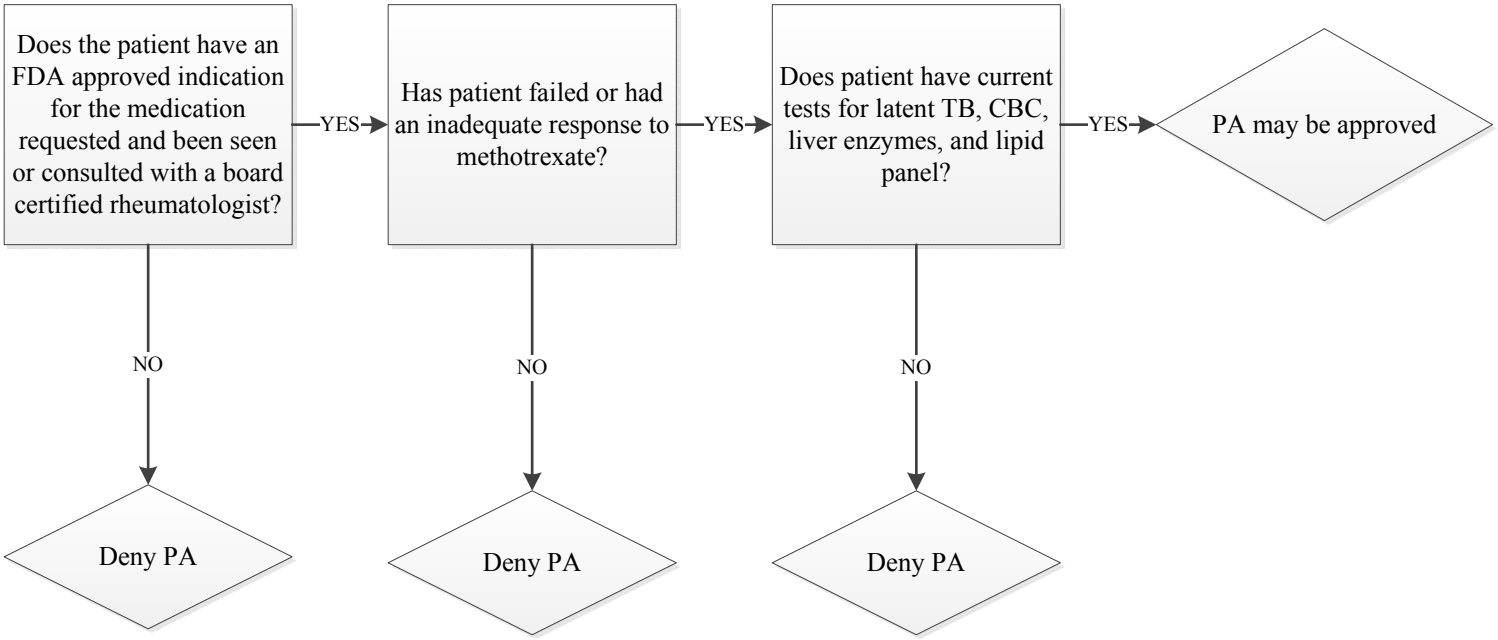
- Prescription must be prescribed by or in consultation with a board certified rheumatologist.
- Patient must have an inadequate response or intolerance to methotrexate.
- Patient must have a test for latent tuberculosis prior to starting Xeljanz.
- Patient must have current lab monitoring prior to starting Xeljanz. (CBC, liver enzymes, lipid panel)
- Use with caution in patients that may be at increased risk for gastrointestinal perforations.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):		
RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH
Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):		
PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	RHEUMATOLOGIST NAME:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:	
Requested Drug and Dosage: □ **Xeljanz**	Diagnosis for this request:
TB test in the past 6 months □ YES □ NO Lab monitoring has occurred and measurements within acceptable limits (i.e., lymphocytes, neutrophils, hemoglobin, lipids, and liver enzymes) □ YES □ NO Have or have had active hepatitis B or C virus □ YES □ NO	Failed Methotrexate therapy Start Date: End Date:

PHYSICIAN SIGNATURE:	DATE:
Part IV: PHARMACY INFORMATION	
PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:
Part V: FOR OFFICIAL USE ONLY	
Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	

South Dakota Department of Social Services
Xeljanz Authorization Algorithm



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

ADULT GROWTH HORMONE

Please fill out form completely

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

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

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
RECIPIENT DOB:	

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

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

QUALIFICATIONS FOR COVERAGE:

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

1. IGF-1 Level:

2. Provocative testing:

Type_____Results_____Date_____

Type_____Results_____Date_____

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

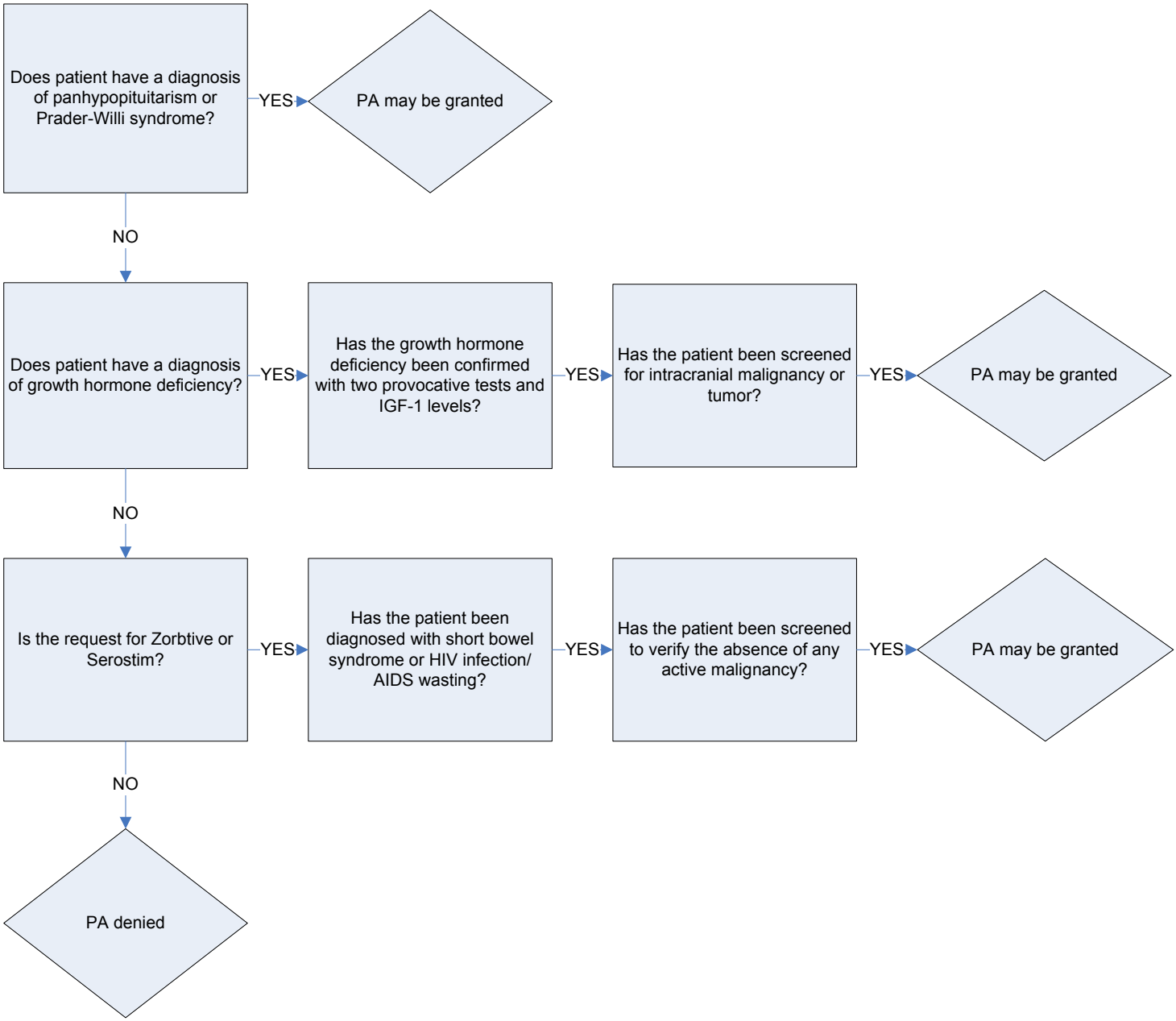
4. Does the patient have any of the following contraindications? Check all that apply.
☐ Proliferative Diabetic retinopathy ☐ Benign intracranial hypertension ☐ NONE

Physician signature:	Date:

Part IV: PHARMACY INFORMATION

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

South Dakota Department of Social Services
Adult Growth Hormone Criteria



ALTABAX PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

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

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

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

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

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

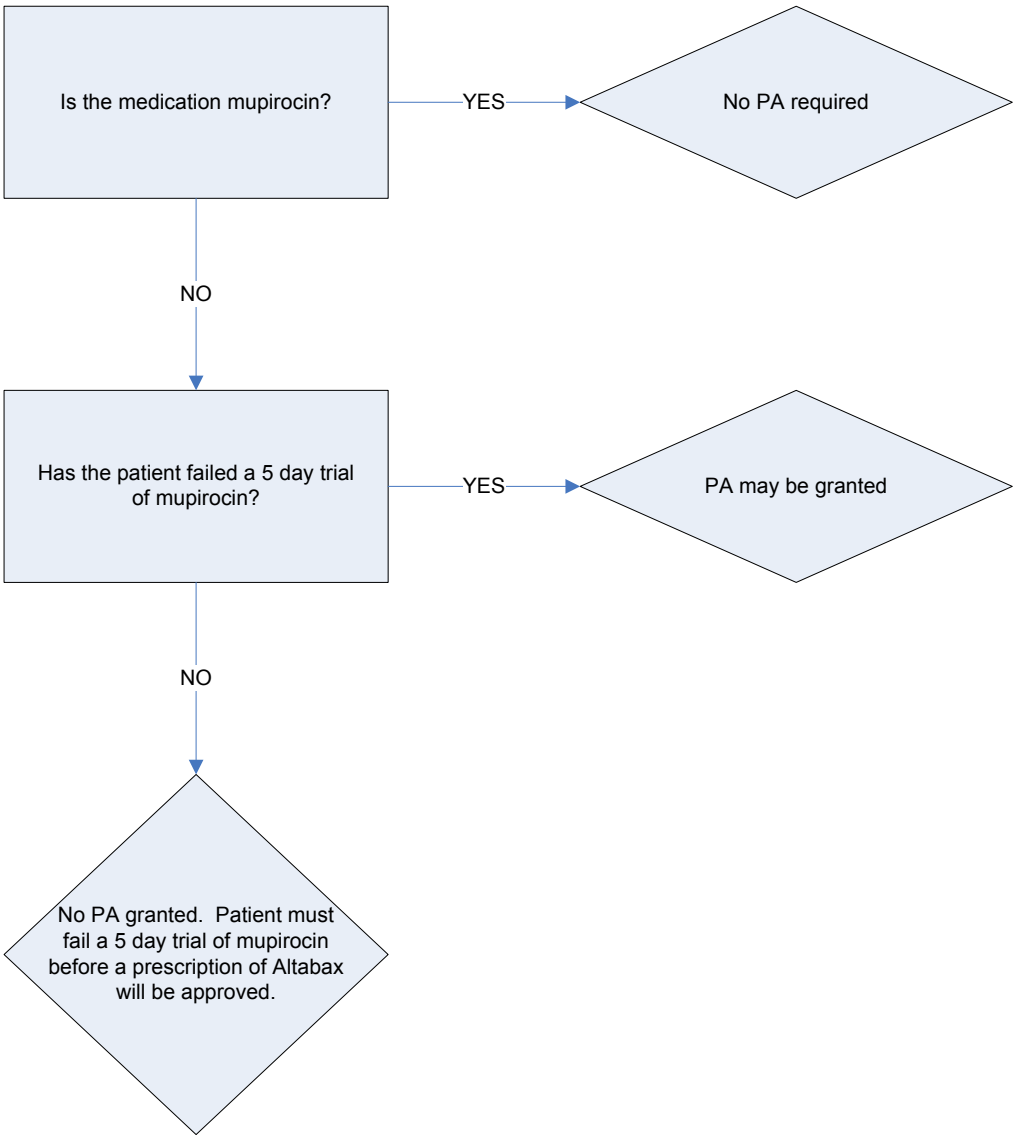
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Altabax Prior Authorization Criteria



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

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

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

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

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

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

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Dosage: (must be completed)

Diagnosis for this request:

Qualifications for coverage:

❑ Failed trial of zolpidem in the last 365 days	Was zolpidem trial for at least 14 days? ❑ YES ❑ NO	Zolpidem Dose:
		Zolpidem Frequency:

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

Medical Justification for use of Ambien CR without trial of zolpidem:

Physician Signature: Date:

Part IV: PHARMACY INFORMATION

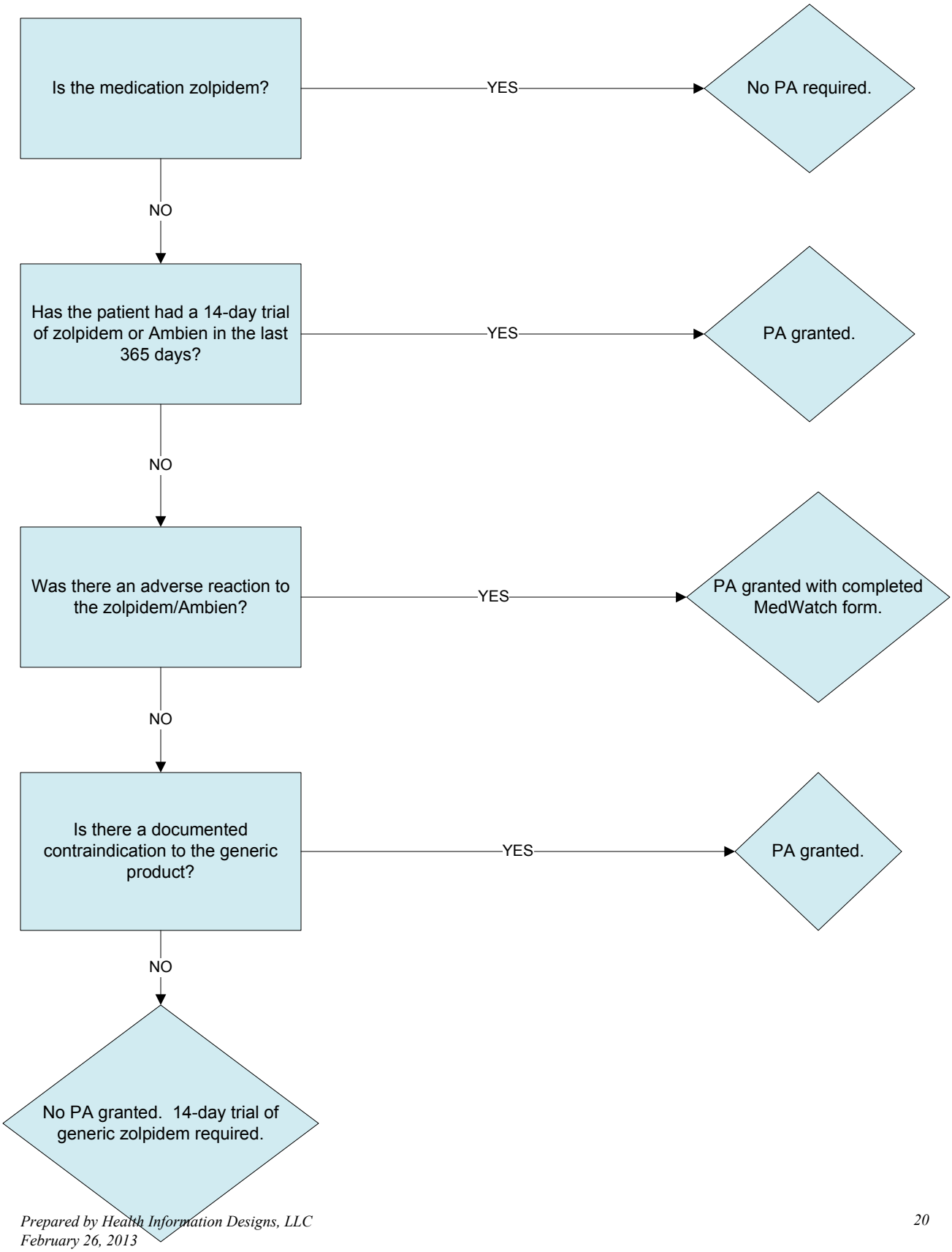
PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services

Ambien CR Criteria Algorithm



AMPYRA
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

- **Patient must have a confirmed diagnosis of multiple sclerosis.**
- **Patient must be 18 years or older.**
- **Patient must have a physiatrist/neurologist involved in therapy.**
- **Patient must not have a history of seizures.**
- **Patient does not have moderate to severe renal impairment (CrCl less than 50mL/min).**

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	PHYSIATRIST/NEUROLOGIST INVOLVED IN THERAPY

CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ AMPYRA _____	Diagnosis for this request:	
Does the patient have a CrCl greater than 50mL/min?	□ Yes	□ No
Does the patient have a history of sezures?	□ Yes	□ No
PHYSICIAN SIGNATURE:		DATE:

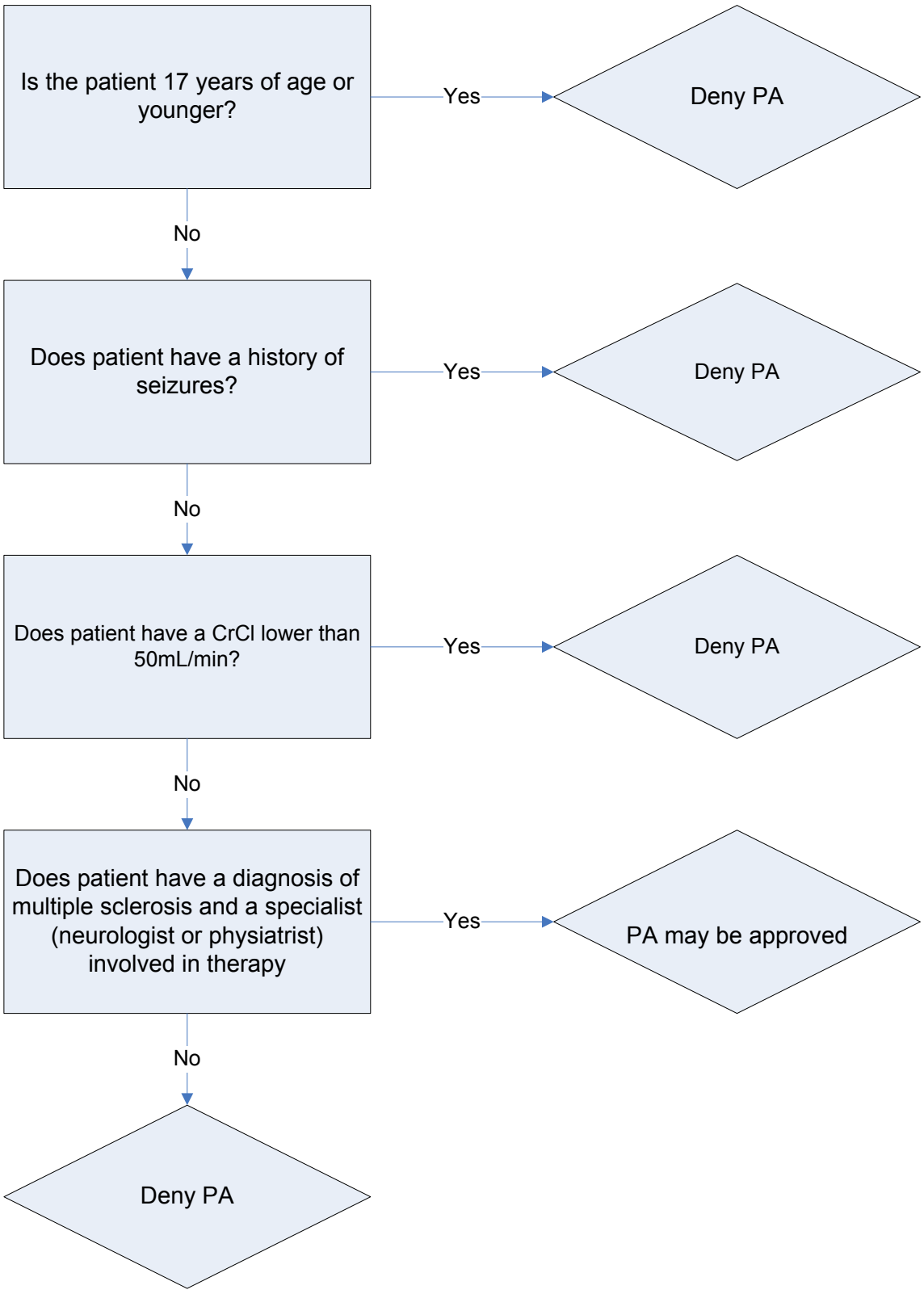
Part IV: PHARMACY INFORMATION

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



AMRIX/FEXMID PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

SD Medicaid requires that patients have a trial of cyclobenzaprine before receiving a PA for Amrix or Fexmid.

- **Cyclobenzaprine does not require a PA**
- **Patient must fail therapy on generic cyclobenzaprine before a PA will be considered.**

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

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

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

Medication Requested: □ **AMRIX** □ **FEXMID**	**Requested Dosage:** (must be completed) **Diagnosis for this request:**

Qualifications for coverage:

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

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

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

Physician Signature: Date:

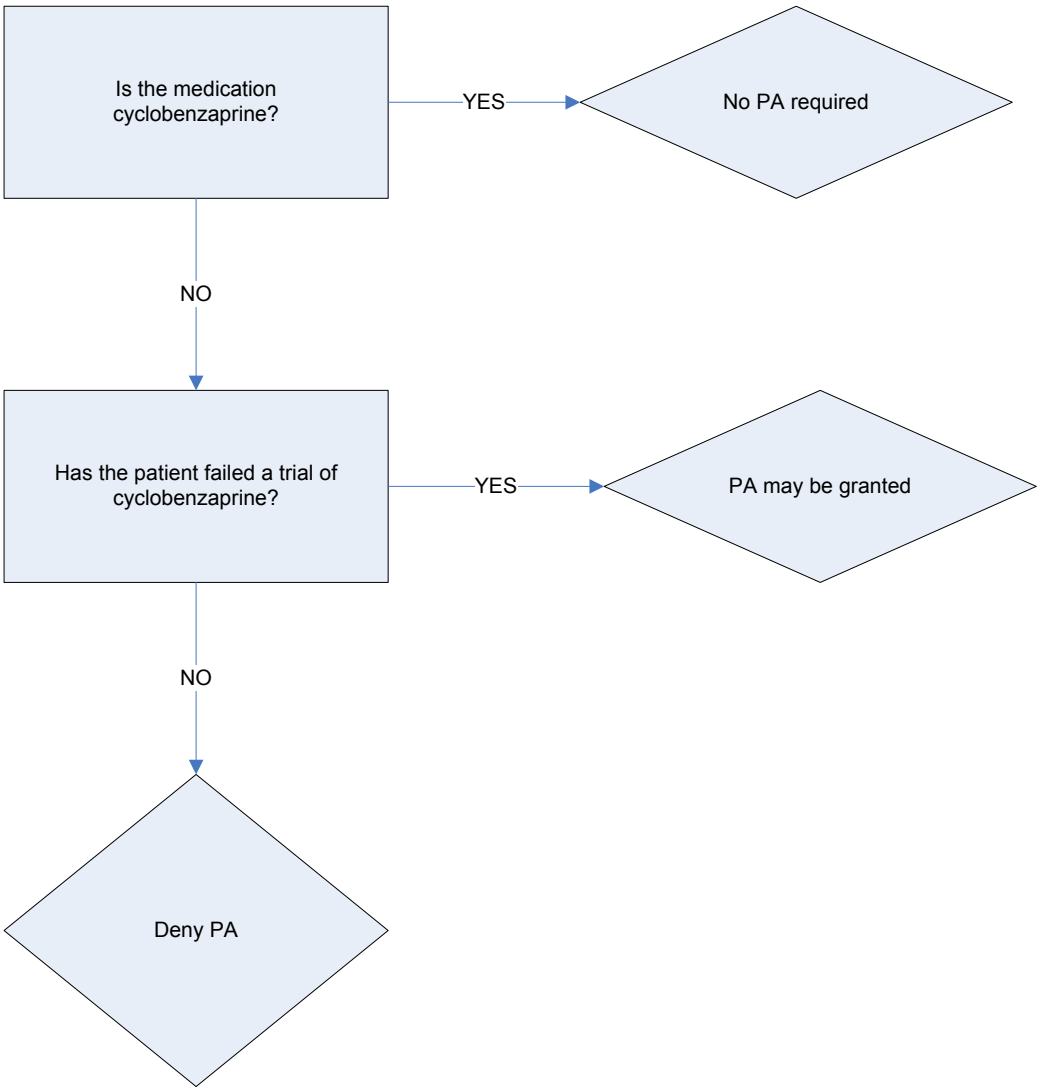
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

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



ANTIDEPRESSANT PRIOR AUTHORIZATION FORM

SD DEPARTMENT OF SOCIAL SERVICES MEDICAL SERVICES DIVISION

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

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

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

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

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

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: (must be completed)

Diagnosis for this request:

Qualifications for coverage:

☐ One failed trial with an antidepressant from tier one.

1. List failed medication

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

Medical Justification for use of a tier two agent without trial of a tier one agent:

Physician Signature: Date:

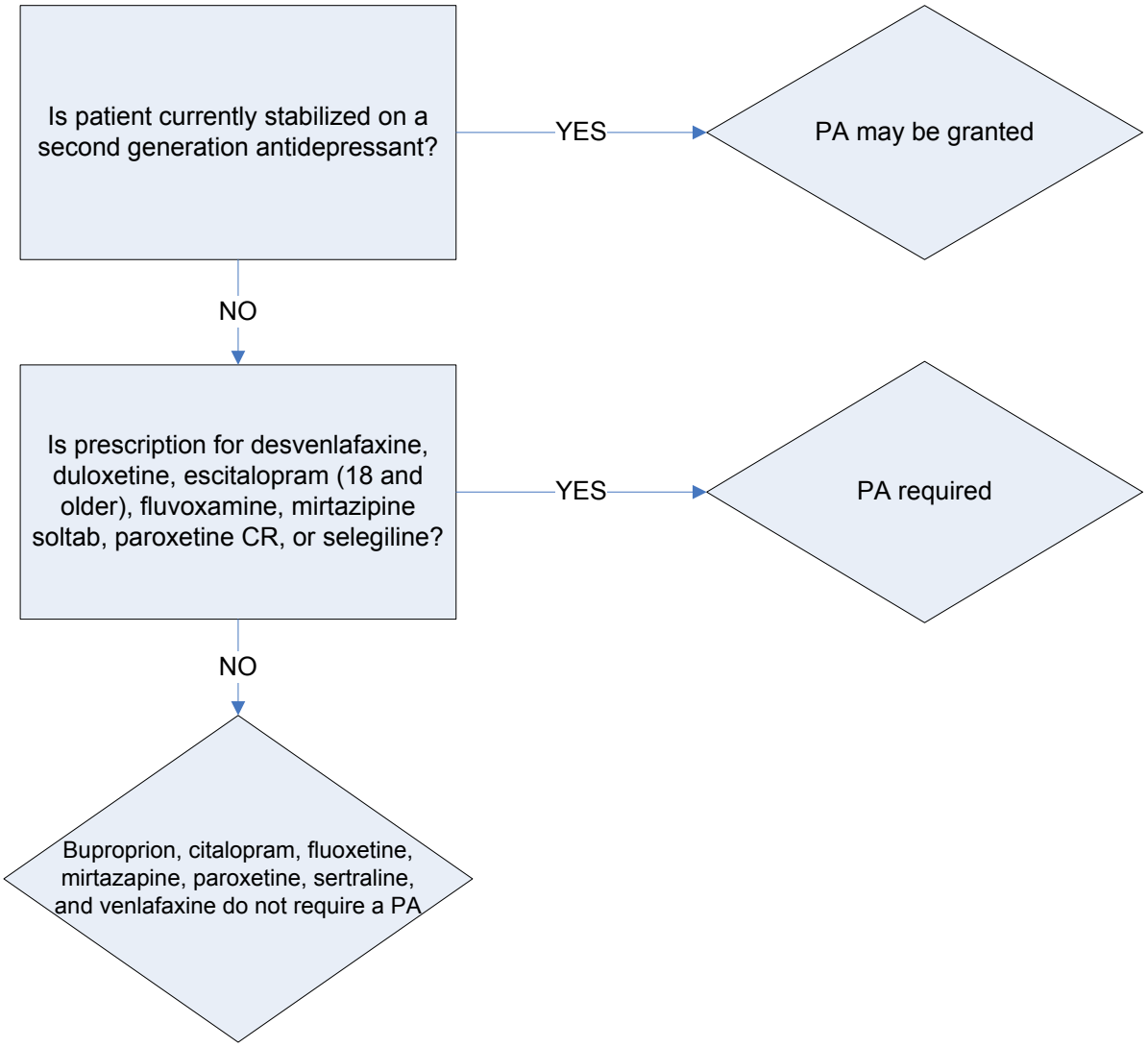
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Antidepressant Authorization Criteria



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:

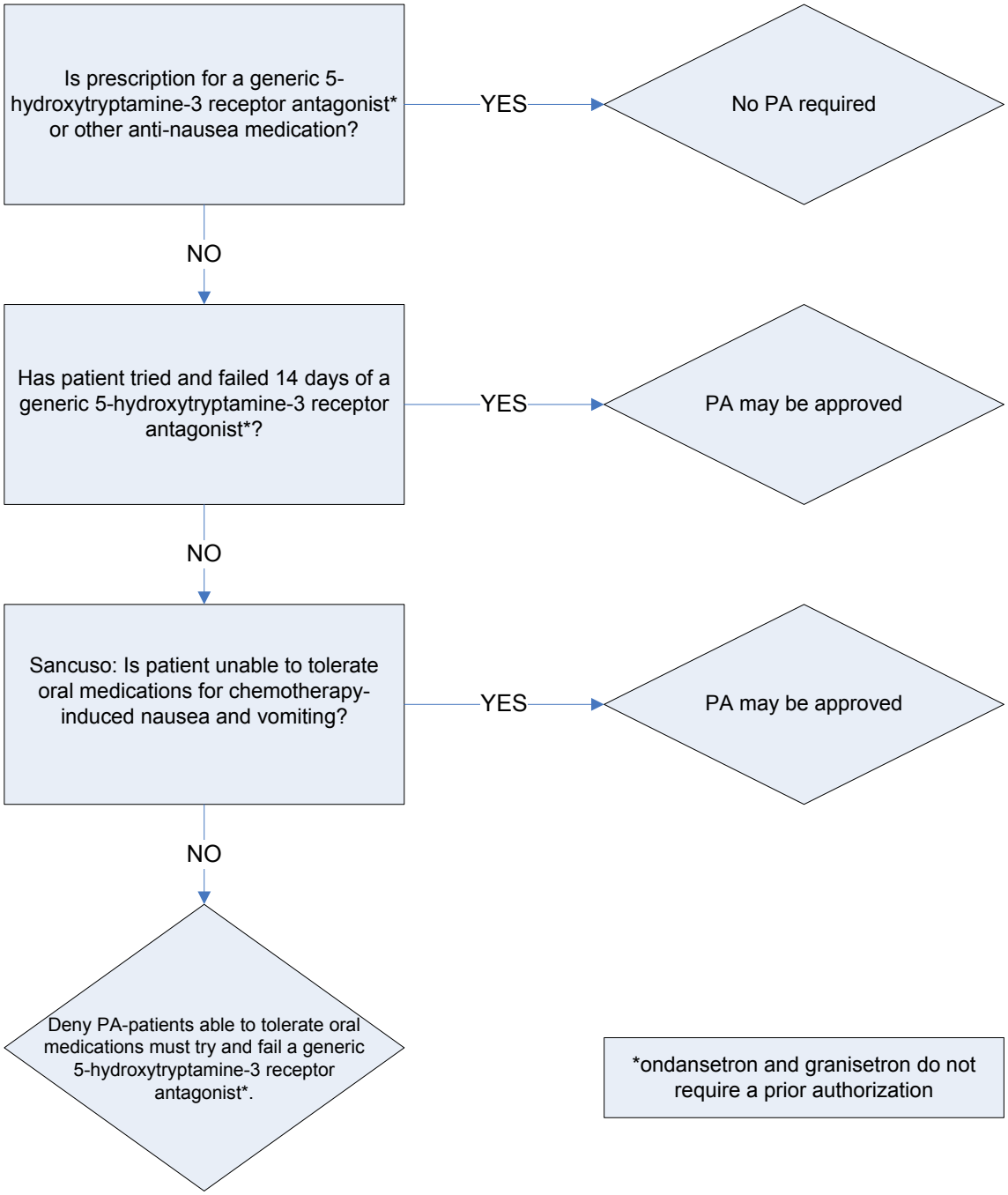
Part IV: PHARMACY INFORMATION

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



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

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

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

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

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

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

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

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

Qualifications for coverage:

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

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

Physician Signature: Date:

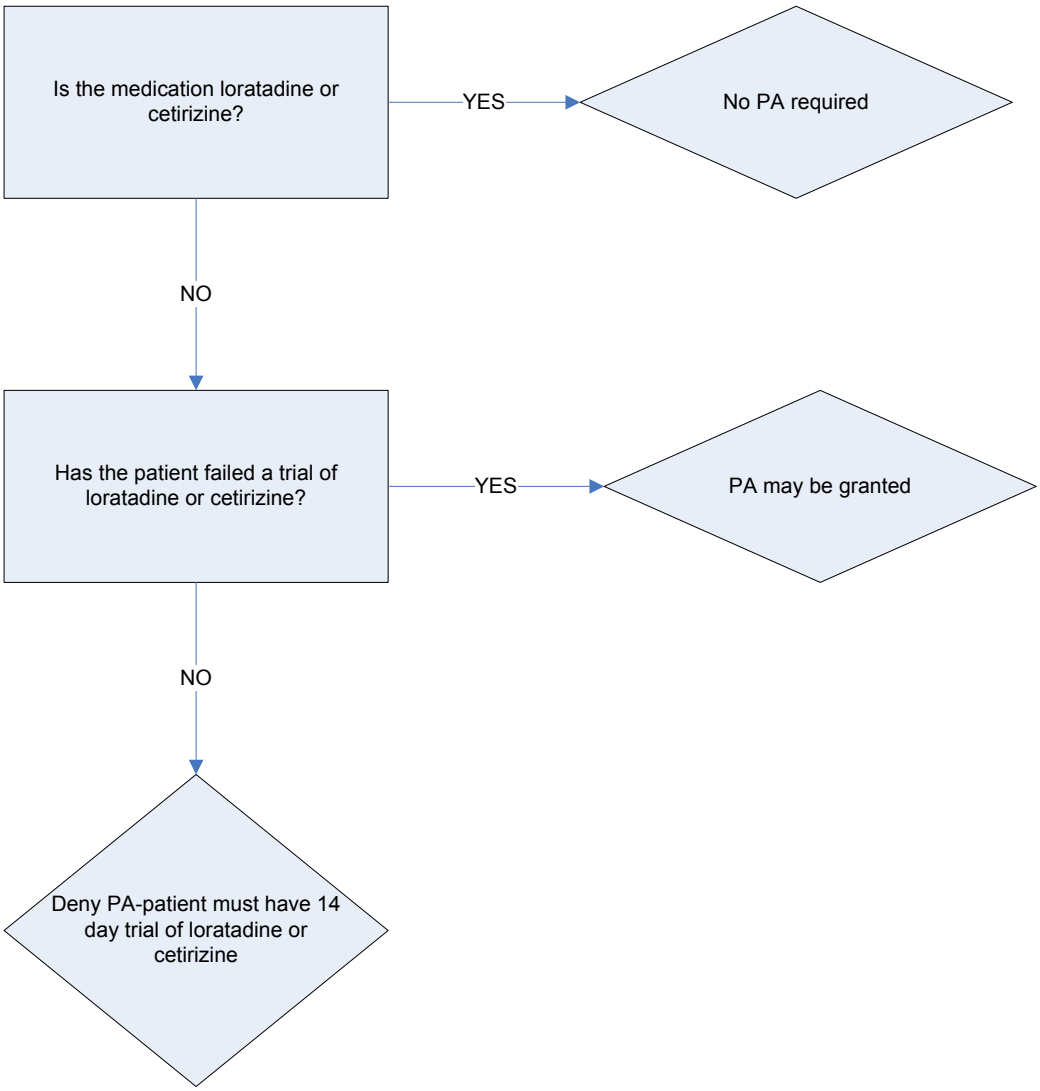
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Antihistamine Prior Authorization Criteria



ATYPICAL ANTIPSYCHOTICS (Second Generation) PRIOR AUTHORIZATION FORM

SD DEPARTMENT OF SOCIAL SERVICES MEDICAL SERVICES DIVISION

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

SD Medicaid requires that patients receiving a new prescription for an atypical antipsychotic (second generation) must have an included indication:

- Traditional antipsychotics (first generation) do not require a prior authorization.
- Children less than 6 years of age must have a psychiatrist, developmental pediatrician, child/adolescent psychiatrist or pediatric neurologist involved in care.
- Two concomitant atypical antipsychotics must involve psychiatrist or mid-level practitioner in collaboration with a psychiatrist.
- If the antipsychotic is prescribed for depression, the recipient must try and fail two antidepressant classes.
- Patients currently stabilized on an atypical antipsychotic (second generation) will not be asked to change medication.

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

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

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

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
City:	PHONE: ( )	FAX: ( )
Two concomitant antipsychotics: Recipient under the care of psychiatrist or mid-level practitioner in collaboration with a psychiatrist? ▫ Yes (please include prescriber's information) ▫ No **90 day transition period will be allowed*		Children less than 6 years of age: Does recipient have a psychiatrist, developmental pediatrician, child/adolescent psychiatrist or pediatric neurologist involved in care? ▫ Yes (please include prescriber's information) ▫ No

Part III: TO BE COMPLETED BY PHYSICIAN:

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

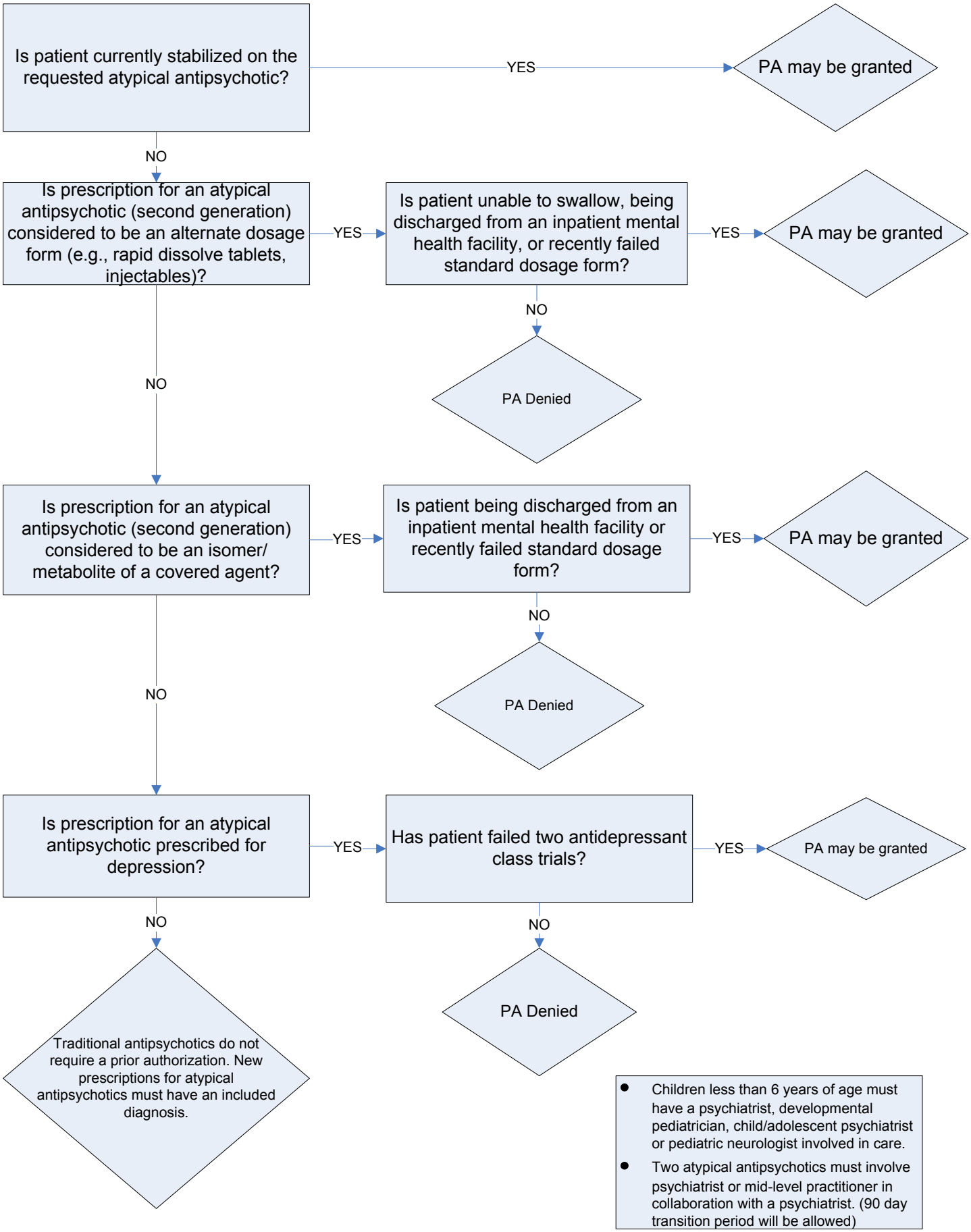
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Atypical Antipsychotics Authorization Criteria



ARB PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

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

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

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

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

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

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

Part III: TO BE COMPLETED BY PHYSICIAN

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

Qualifications for coverage:

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

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

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

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

Physician Signature: Date:

Part IV: TO BE COMPLETED BY PHARMACY

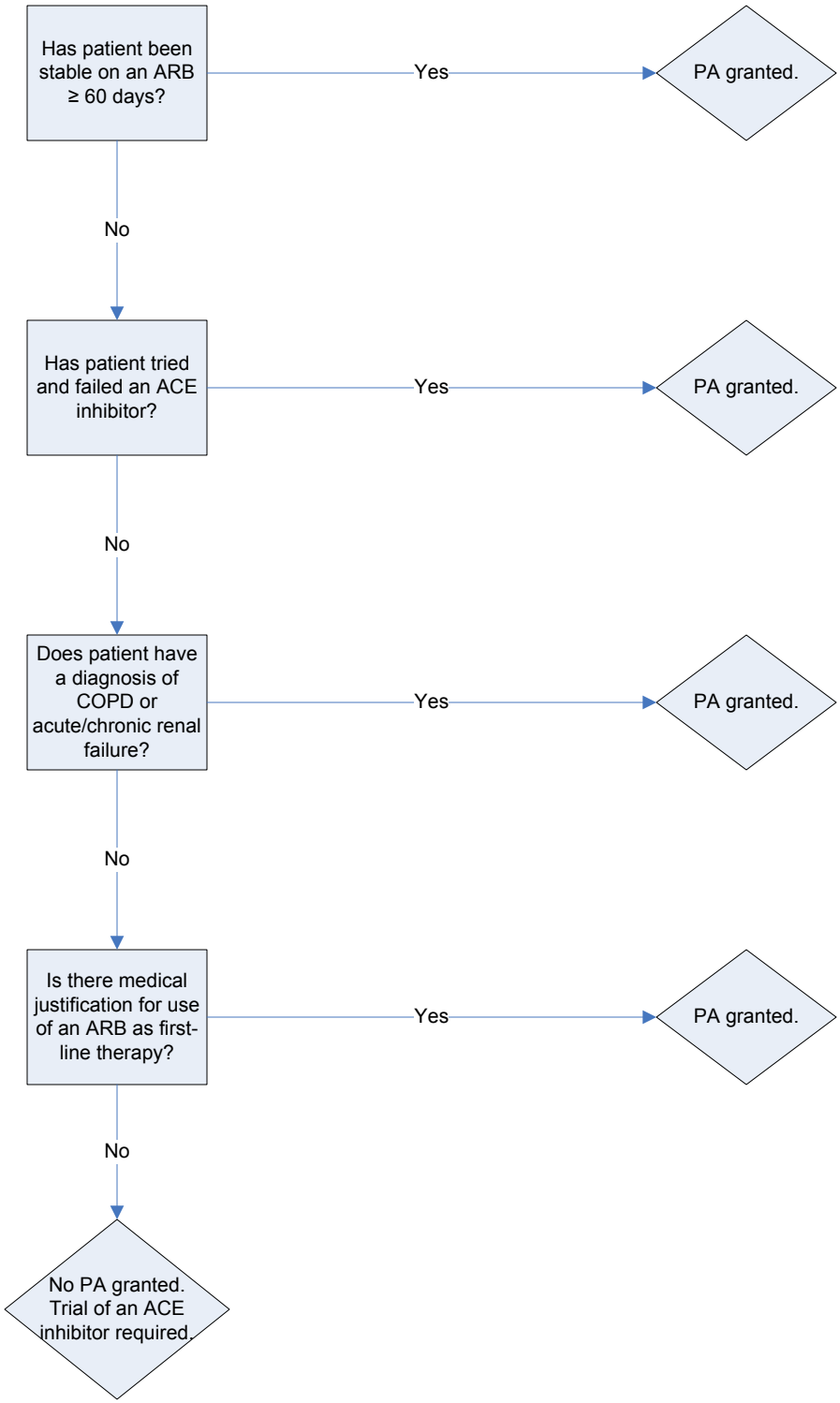
PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services

ARB Authorization Criteria Algorithm



AUBAGIO
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

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

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

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

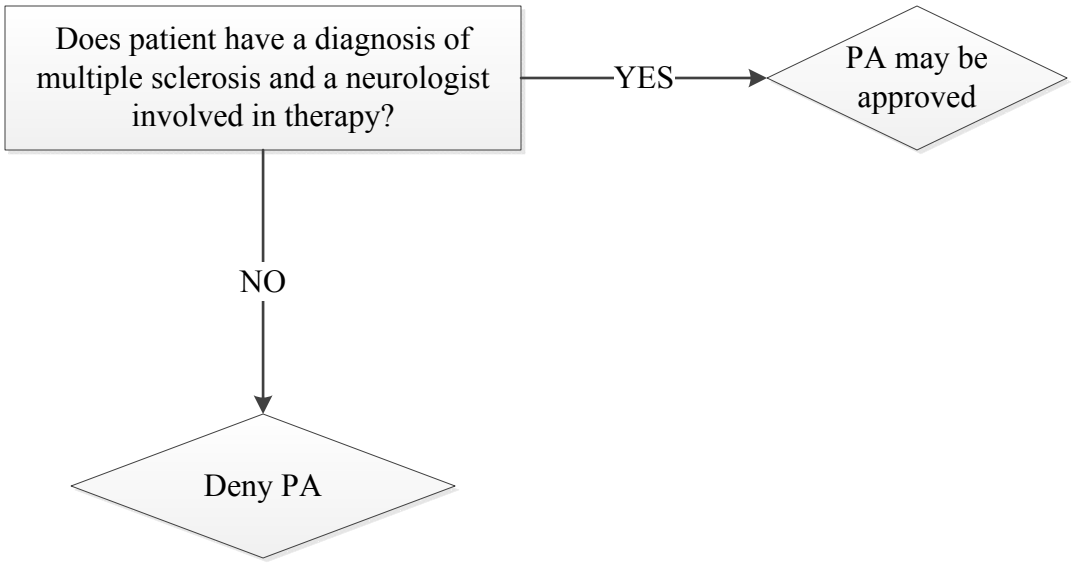
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Aubagio Authorization Algorithm



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

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

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

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

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

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

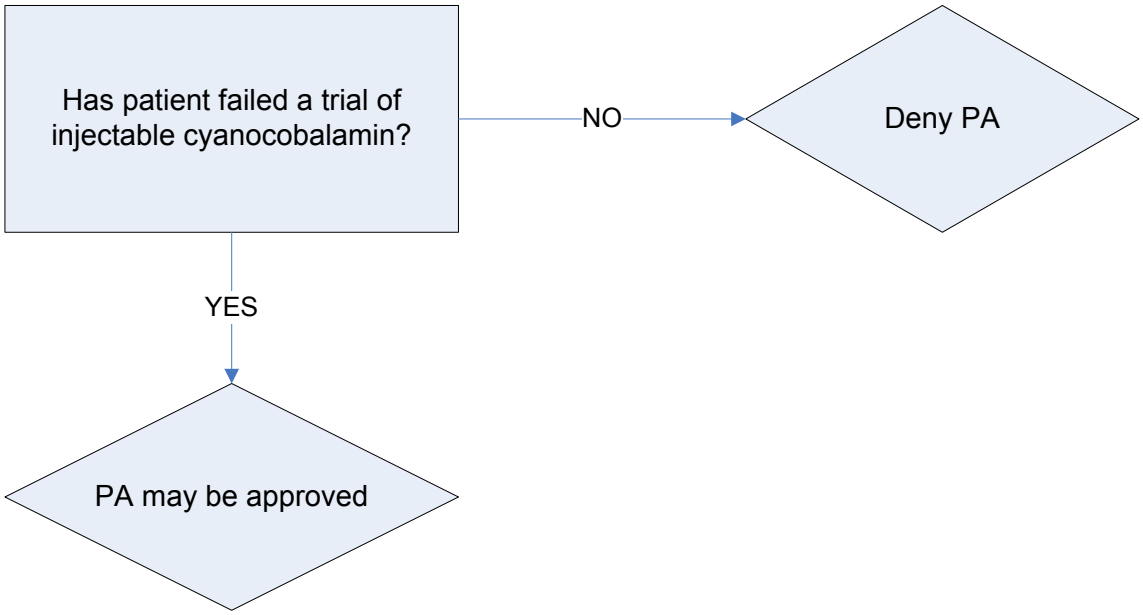
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

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



DISPENSE AS WRITTEN PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

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

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

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

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

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

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

Part III: TO BE COMPLETED BY PHYSICIAN

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

Qualifications for coverage:

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

If yes, please indicate the reason for discontinuation below.

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

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

Physician Signature: Date:

Part IV: TO BE COMPLETED BY PHARMACY

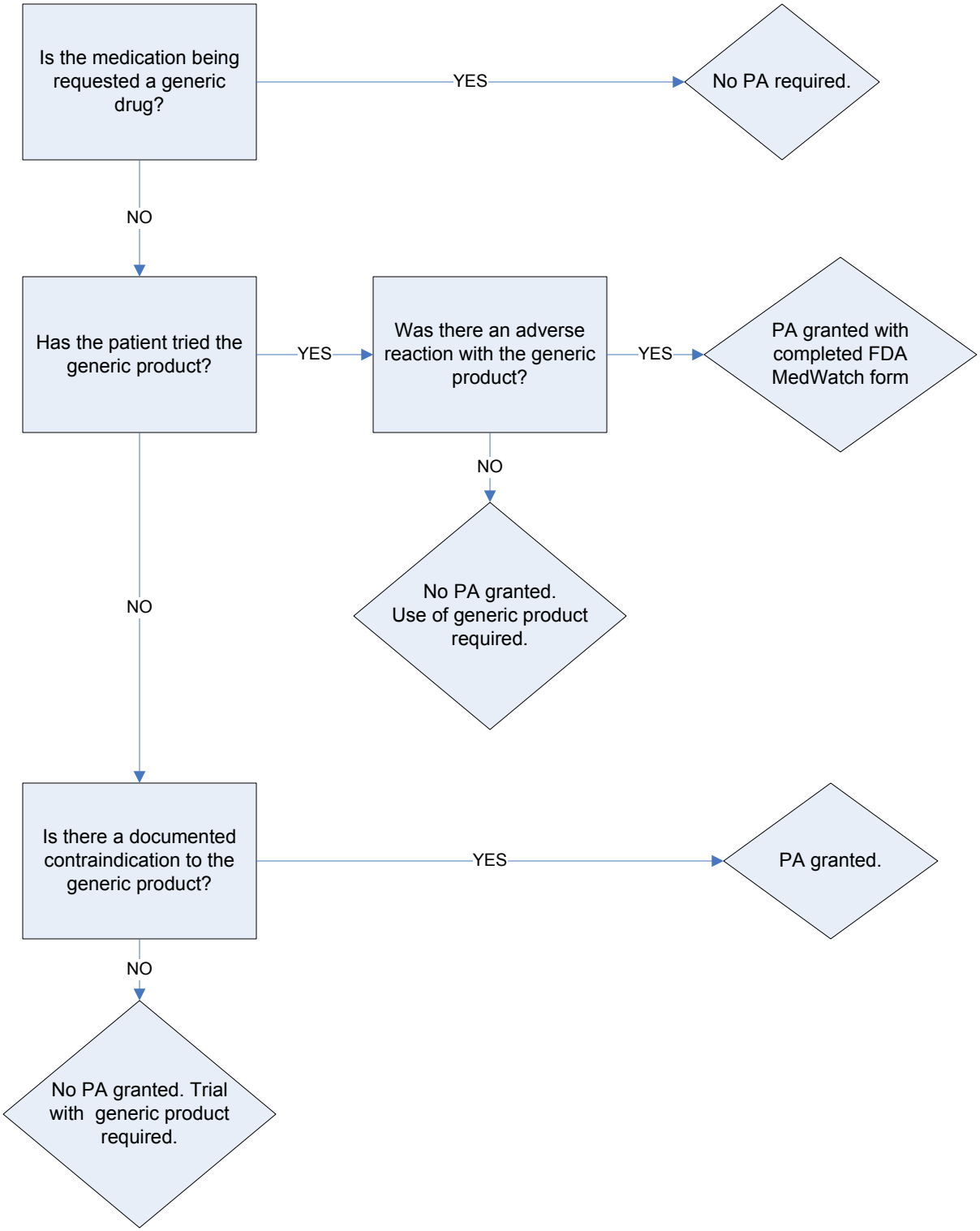
PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services

Dispense As Written Authorization Criteria Algorithm



DESOXYN PA FORM
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

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

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

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

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

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

Part III: TO BE COMPLETED BY PHYSICIAN

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

Qualifications for coverage:

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

Physician Signature:	Date:

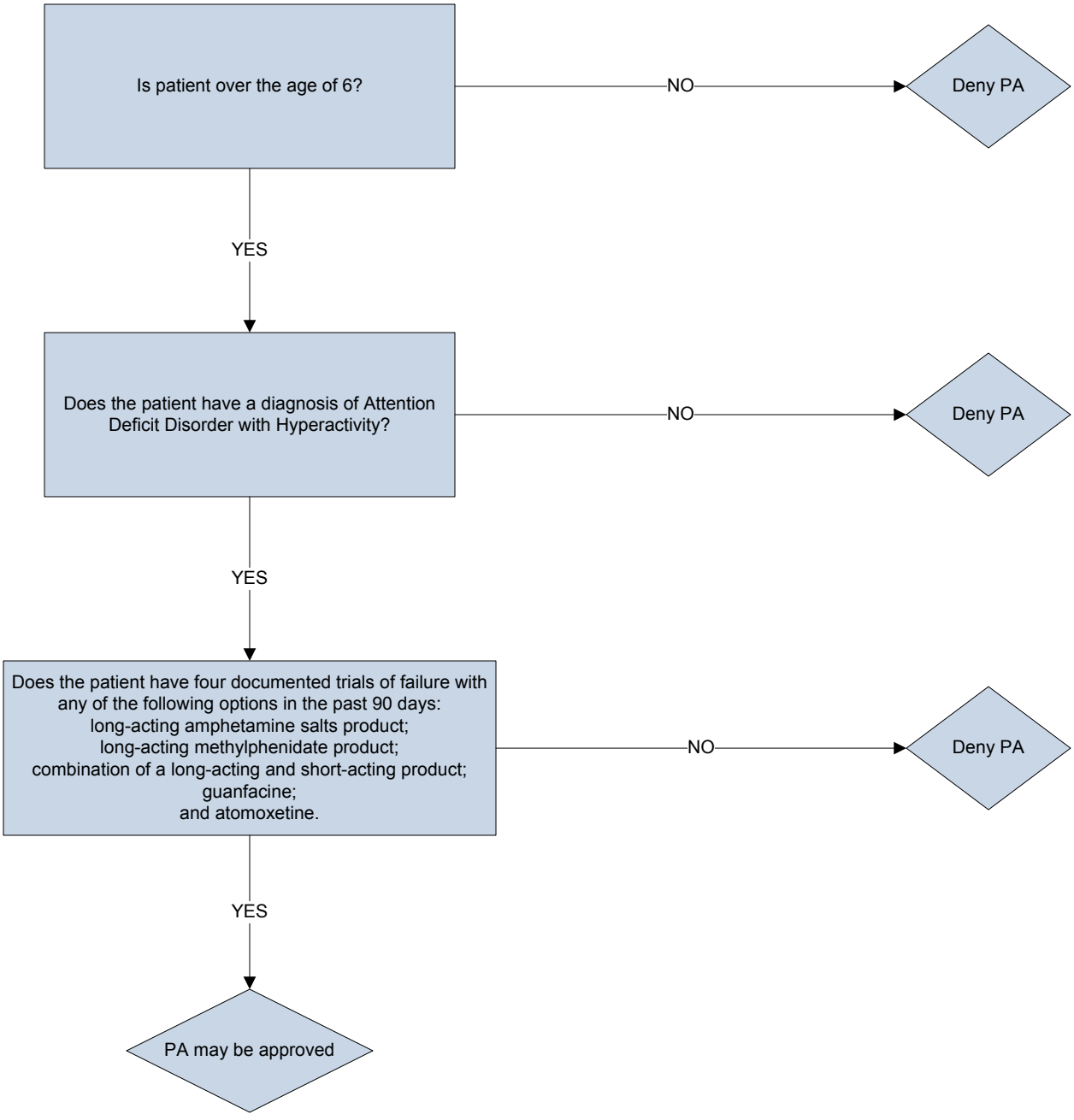
Part IV: TO BE COMPLETED BY PHARMACY

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Desoxyn Prior Authorization Criteria



DIFICID
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

- **Patient must have diagnosis of *Clostridium difficile*-associated diarrhea (CDAD)**
- **Patient must be ≥ 18 years of age**
- **Patient must have been treated per the current guidelines and failed**
- **Compounded oral vancomycin is covered without prior authorization**
- **Metronidazole is covered without prior authorization**

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Dificid	Diagnosis for this request:
Failed therapy:	Dosage:
	Frequency:
PHYSICIAN SIGNATURE:	DATE:

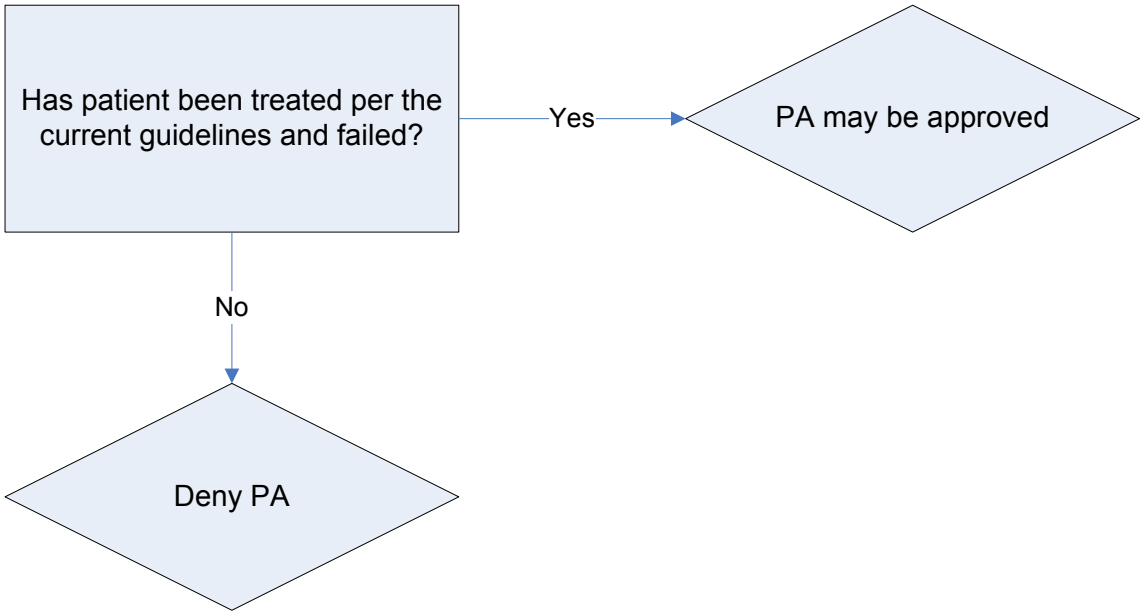
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Dificid Prior Authorization Algorithm



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

*Compounded oral vancomycin is covered without prior authorization

*Metronidazole is covered without prior authorization

EXTAVIA
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

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

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

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

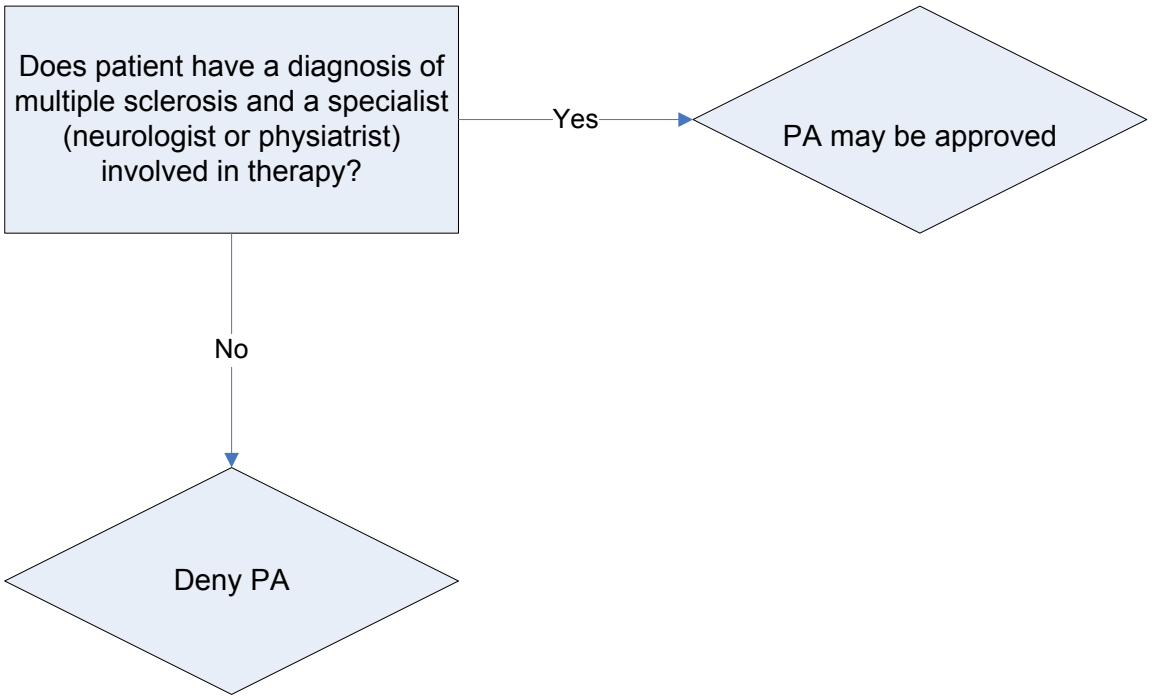
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Extavia Prior Authorization Algorithm



GILENYA
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

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

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

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

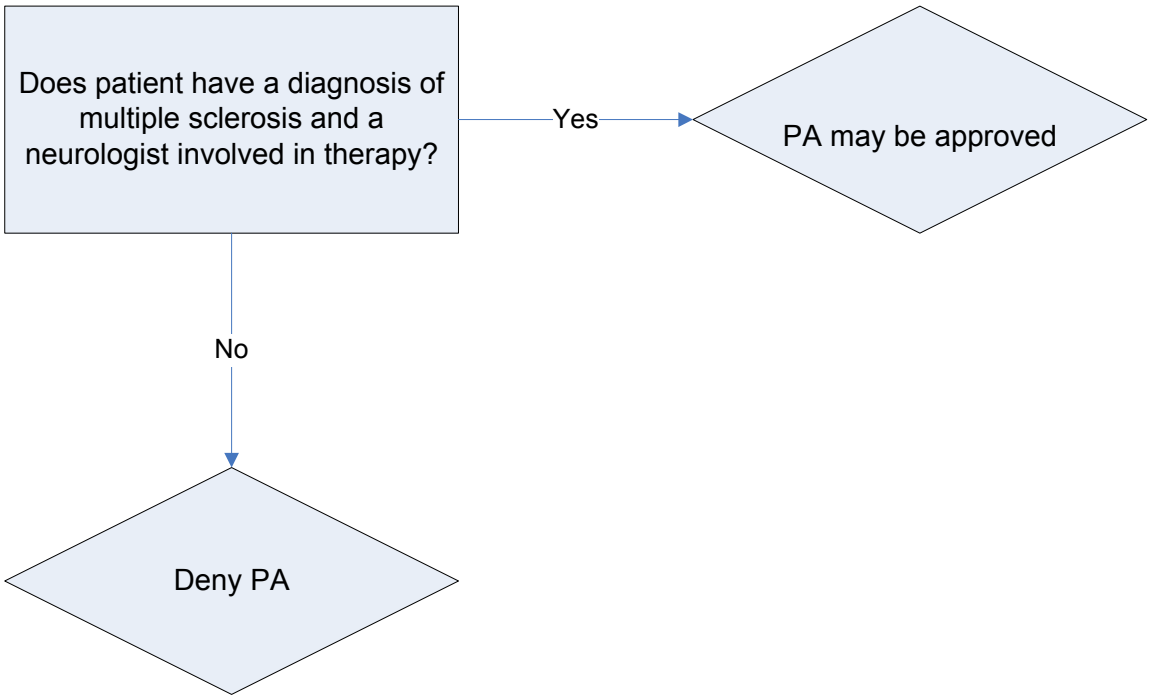
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Gilenya Prior Authorization Algorithm



GRALISE
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

- **Patient must have a diagnosis of postherpetic neuralgia.**
- **Patient must first try and fail a 3 month course of gabapentin**

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Gralise	Diagnosis for this request:
Failed therapy:	Dosage:
	Frequency:
PHYSICIAN SIGNATURE:	DATE:

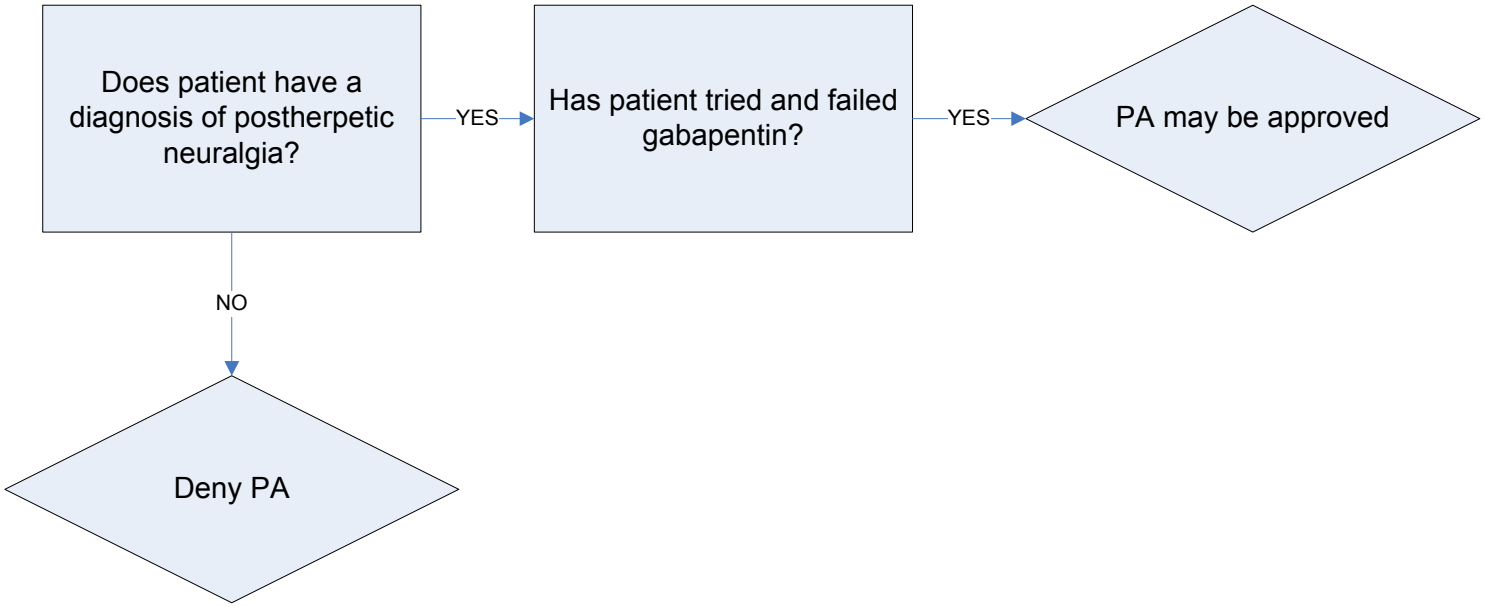
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Gralise Prior Authorization Algorithm



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:

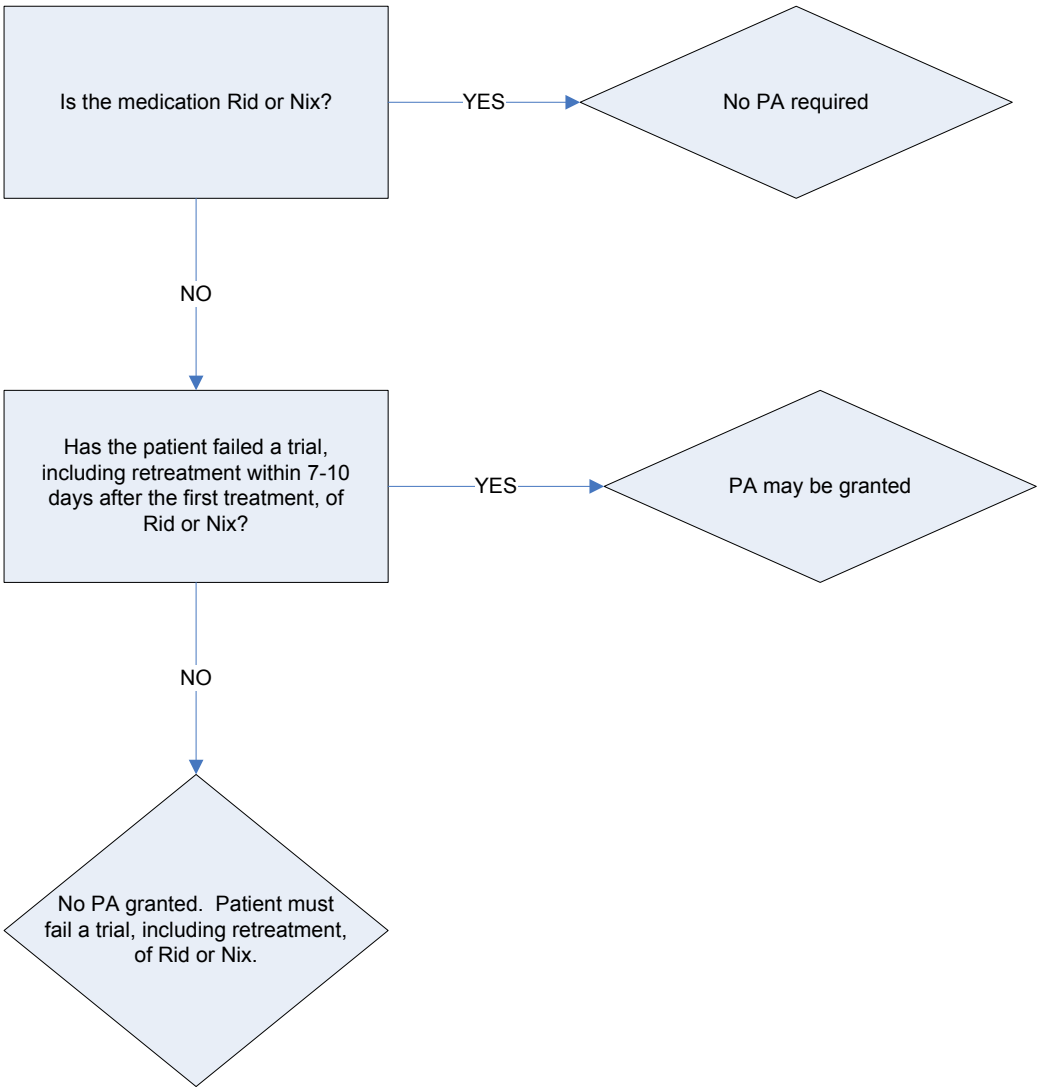
Part IV: PHARMACY INFORMATION

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



Hepatitis C Virus (HCV) Medication
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

SD Medicaid requires that patients receiving a new prescription for Incivek or Victrelis must have an FDA approved indication.

- Incivek and Victrelis patients must have a diagnosis of hepatitis C genotype 1.
- Incivek and Victrelis patients must be 18 years of age or older.
- Incivek and Victrelis patients must also be taking ribavirin and peg-interferon.

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ **Incivek** □ **Victrelis**	Diagnosis for this request:	Genotype:
	Ribavirin dose: Peg-interferon dose:	
PHYSICIAN SIGNATURE: DATE:		

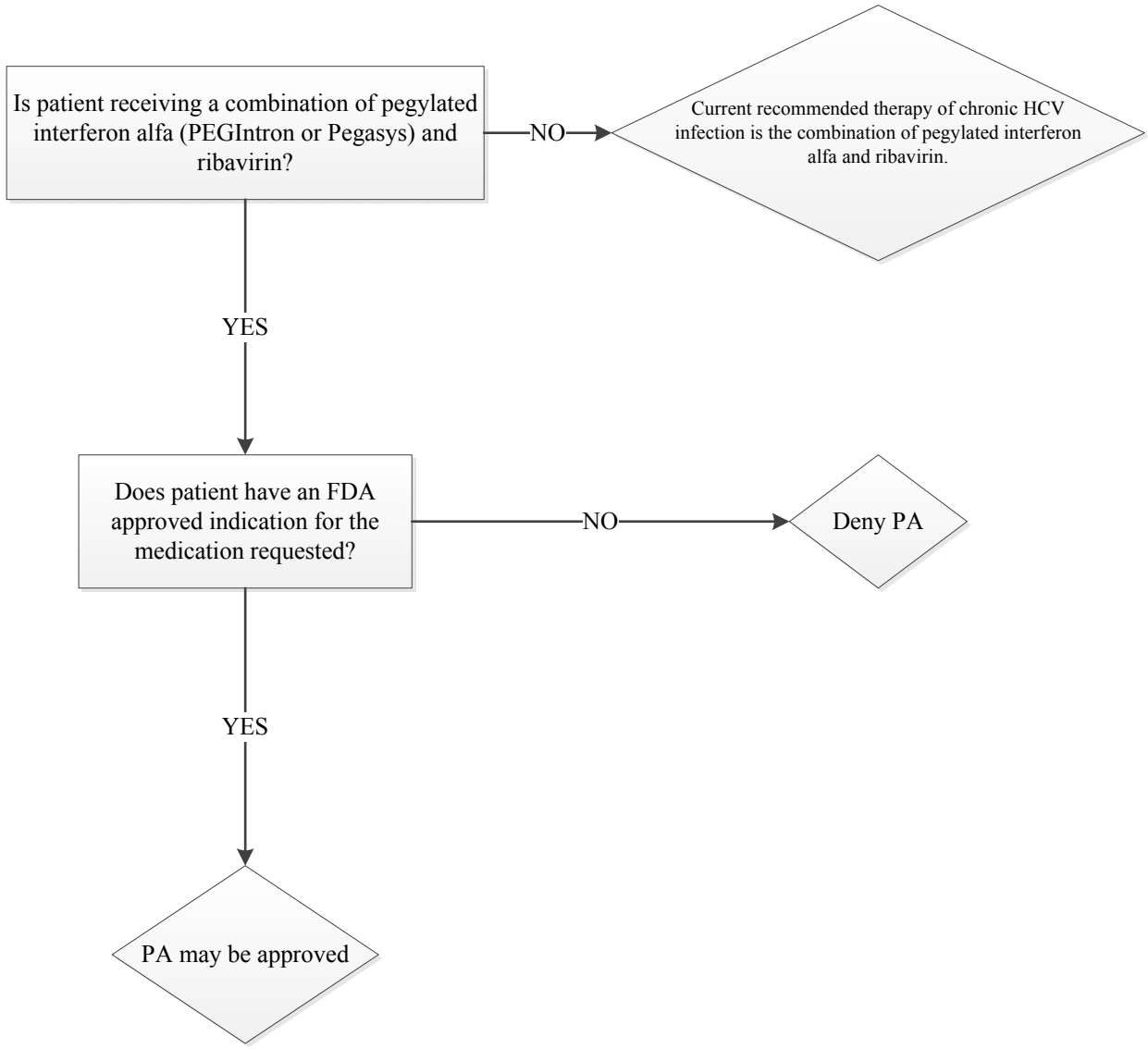
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

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



HORIZANT
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

SD Medicaid requires that patients receiving a new prescription for Horizant must have a diagnosis of restless leg syndrome.

- **Gabapentin and benzodiazepines do not require a prior authorization.**

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Horizant	Diagnosis for this request:
Failed therapy:	Dosage:
	Frequency:
PHYSICIAN SIGNATURE:	DATE:

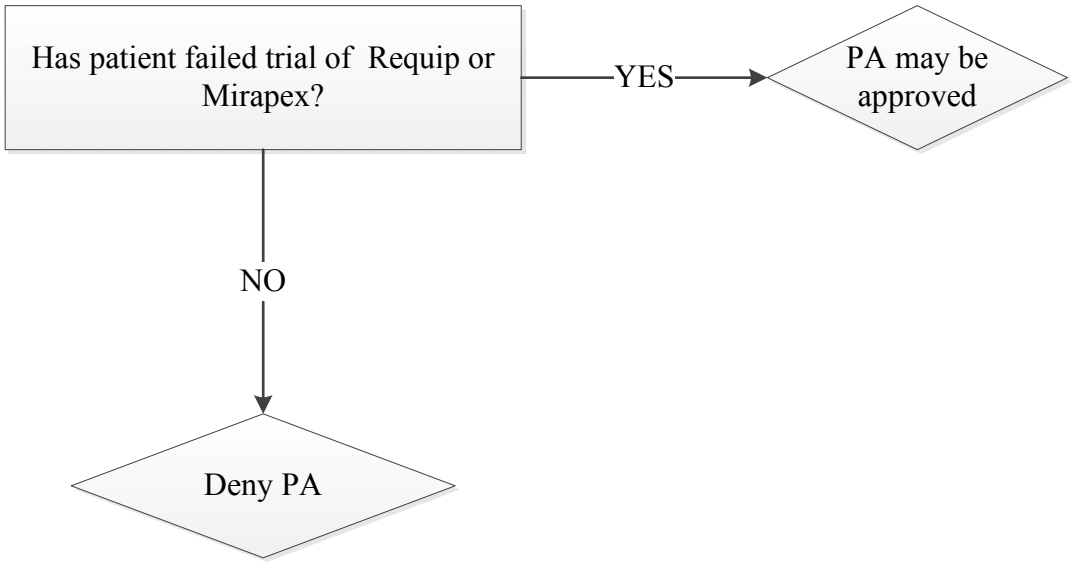
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Horizant Authorization Algorithm



TARGETED IMMUNE MODULATORS
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

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

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

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

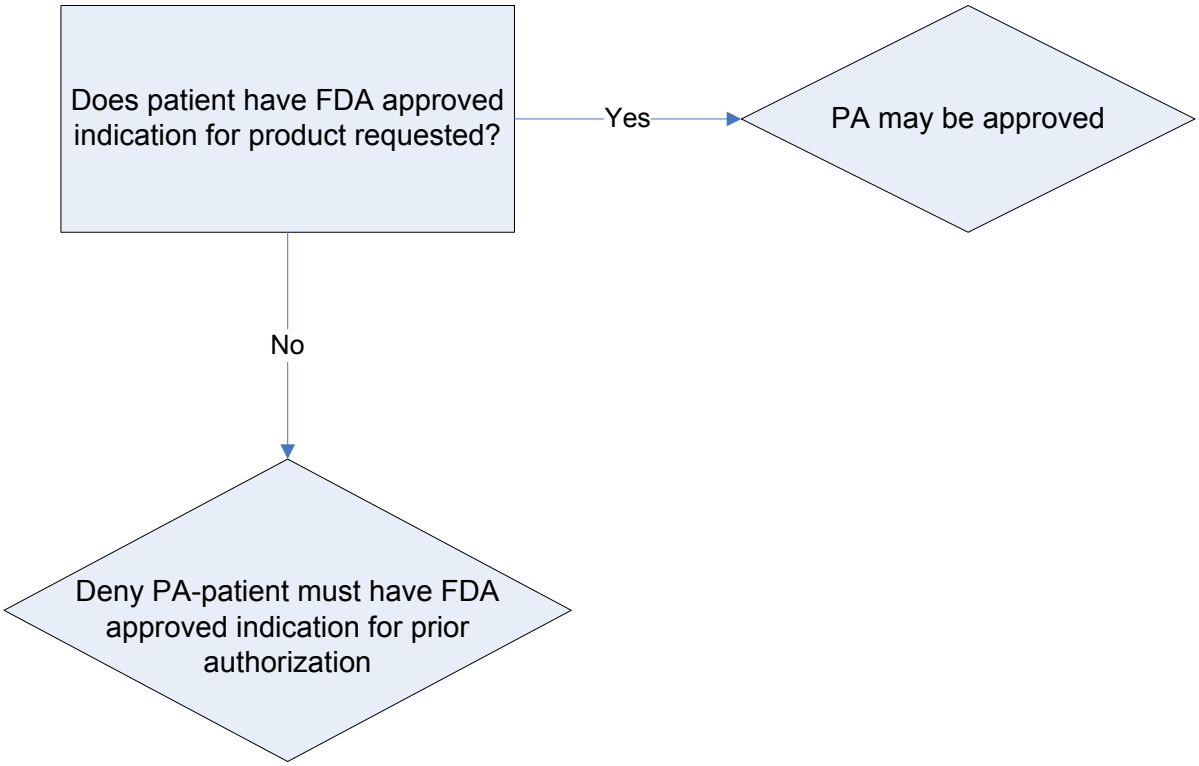
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Targeted Immune Modulators Authorization Algorithm



LIDODERM
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

- **Patient must have a diagnosis of post-herpetic neuralgia.**

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Lidoderm	Diagnosis for this request:
Dosing Instructions:	
PHYSICIAN SIGNATURE:	DATE:

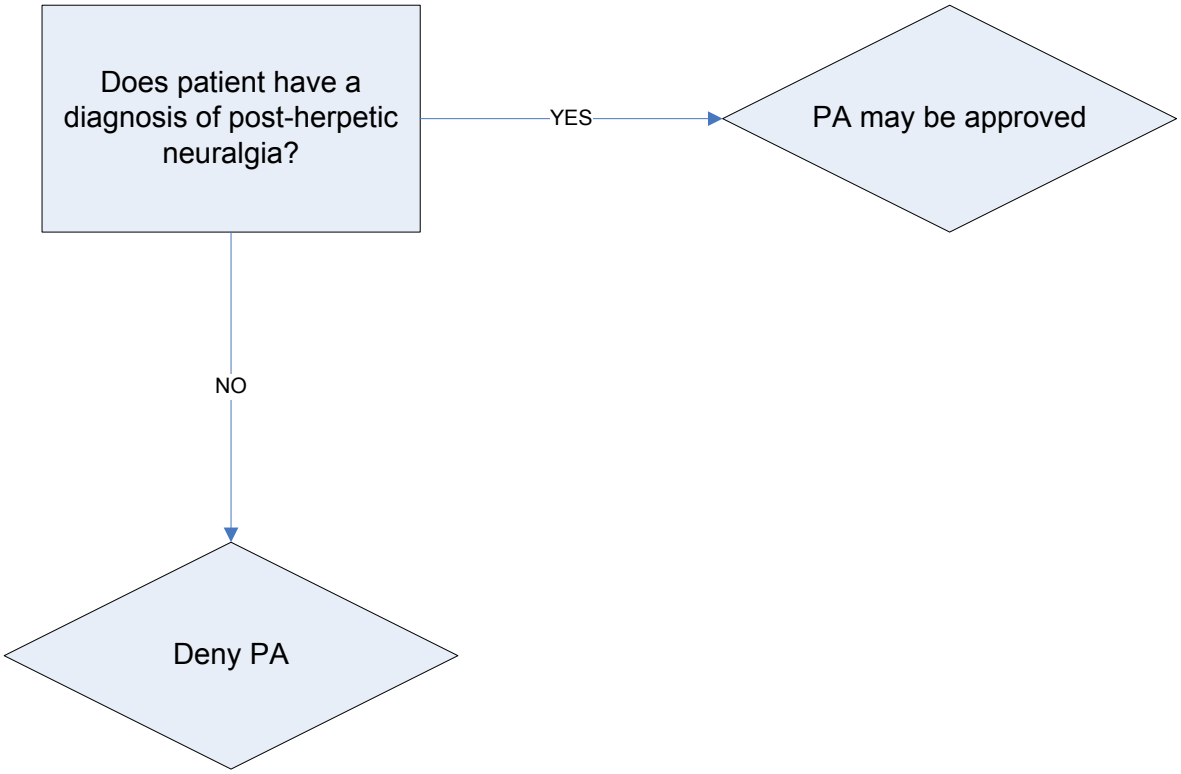
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Lidoderm Prior Authorization Algorithm



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

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

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

- **Patient must try metoclopramide.**

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

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

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

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

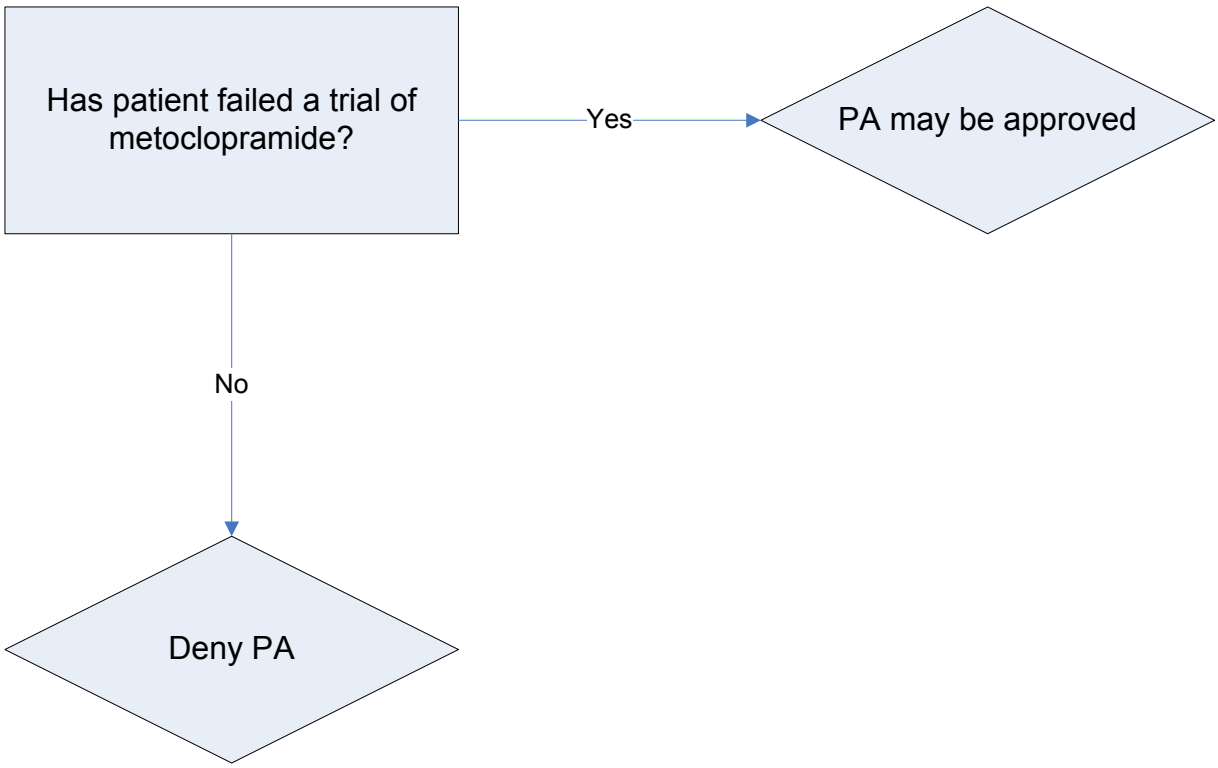
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Metozolv Prior Authorization Criteria



MOXATAG PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

SD Medicaid requires that patients have a trial of amoxicillin before receiving a PA for Moxatag.

- **Amoxicillin does not require a PA**
- **Patient must fail therapy on generic amoxicillin before a PA will be considered.**

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

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

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

Medication Requested: □ **MOXATAG**	**Requested Dosage:** (must be completed) **Diagnosis for this request:**

Qualifications for coverage:

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

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

Medical Justification for use of Moxatag without trial of amoxicillin:

Physician Signature: Date:

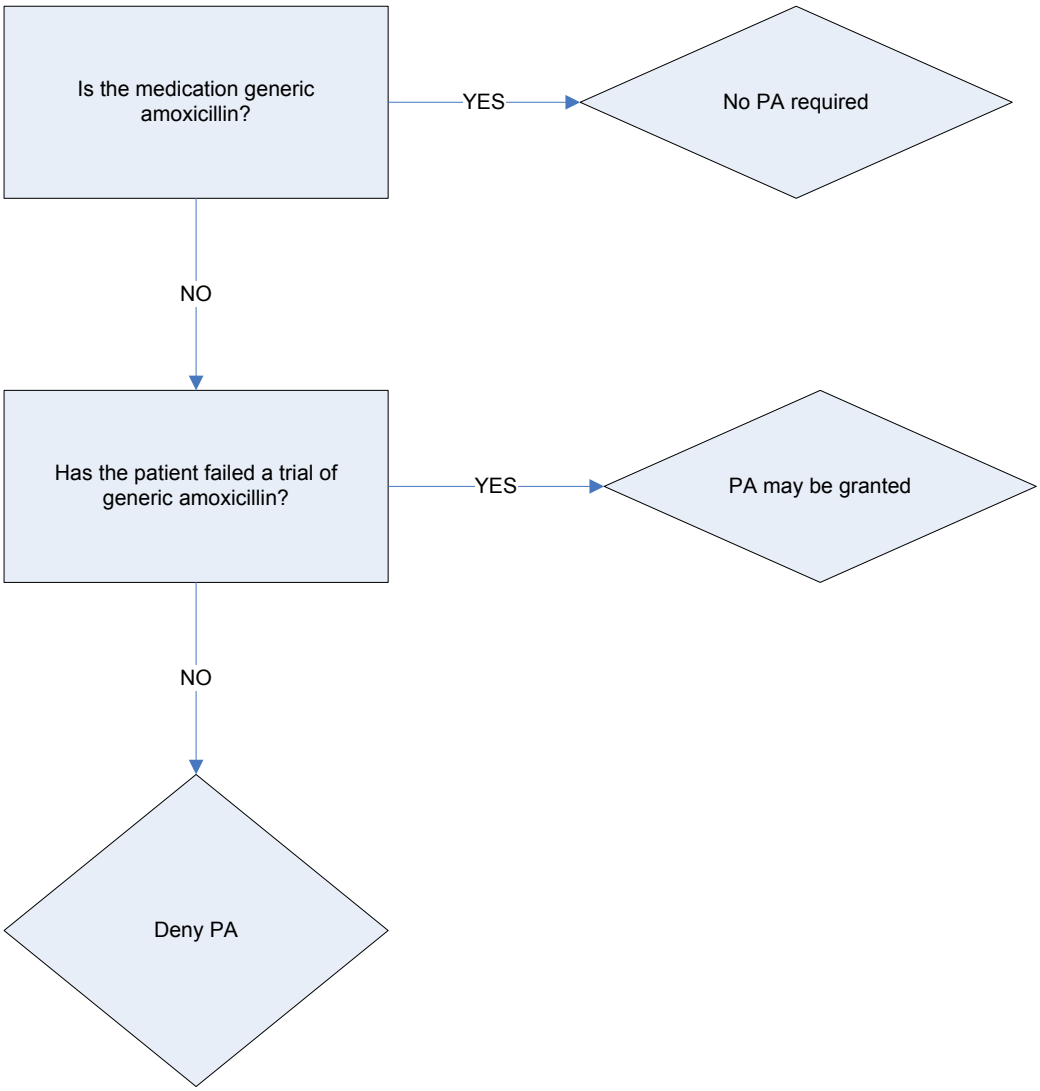
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Moxatag Prior Authorization Criteria



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

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

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

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

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

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

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug: (must be completed)

□ EMBEDA □ OPANA □ KADIAN □ AVINZA □ EXALGO □ FENTORA

□ BUTRANS □ ABSTRAL □ COMBUNOX □ ONSOLIS □ MAGNACET

Qualifications for coverage:

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

Physician Signature:	Date:

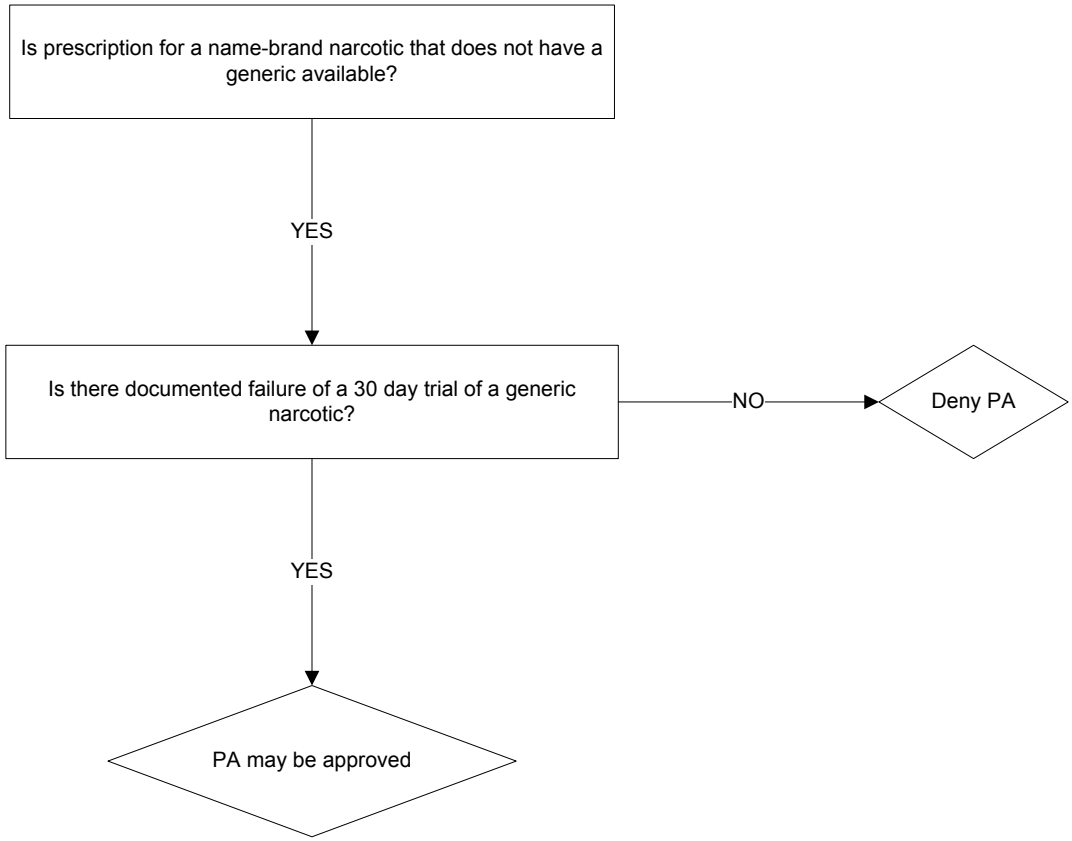
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

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



NASAL STEROIDS
for Allergic Rhinitis
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

SD Medicaid requires that patients receiving a new prescription for a nasal steroid for allergic rhinitis must meet the following criteria:

- Patient must first try a generic nasal steroid.
- Fluticasone and triamcinolone do not require a prior authorization.

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ **Qnasl** □ **Rhinocort** □ **Omnaris** □ **Zetonna** □ **Dymista** □ **Nasonex** □ **Veramyst**	Diagnosis for this request:
PHYSICIAN SIGNATURE: DATE:	

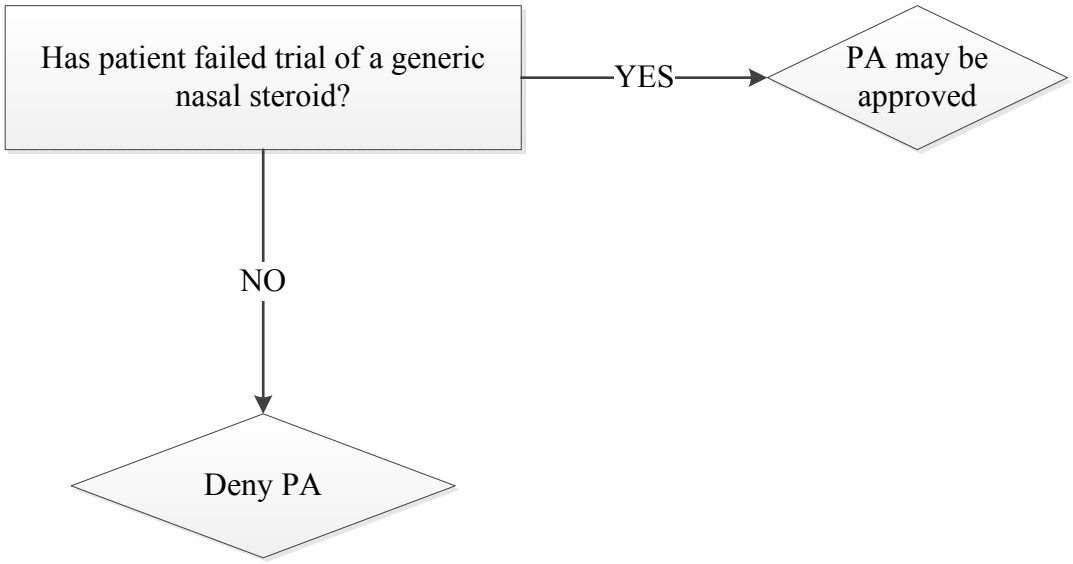
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Nasal Steroids Authorization Algorithm



NEXICLON
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

SD Medicaid requires that patients receiving a new prescription for Nexiclon must first try clonidine.

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

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Nexiclon	Diagnosis for this request:
Failed therapy:	Dosage:
	Frequency:
PHYSICIAN SIGNATURE:	DATE:

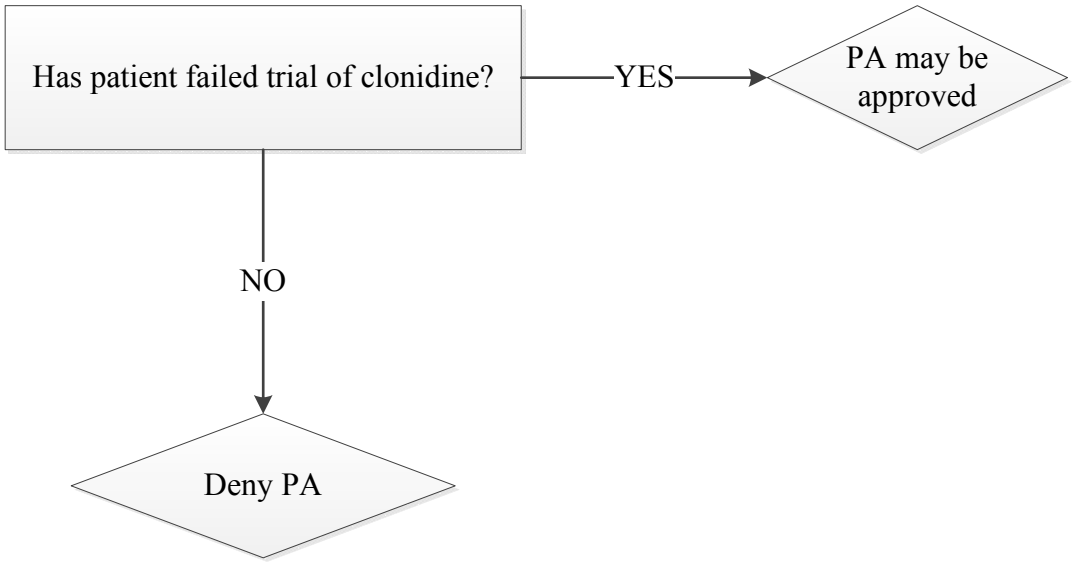
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Nexiclon Authorization Algorithm



NOVANTRONE
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

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

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

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

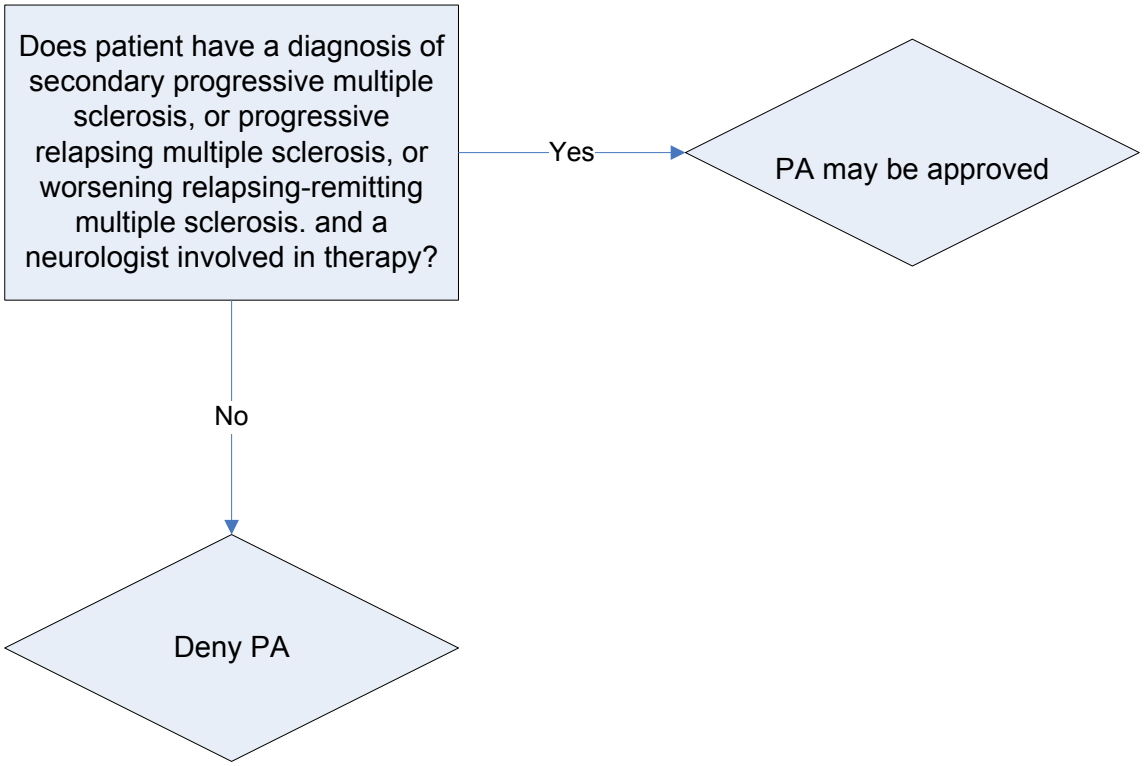
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Novantrone Prior Authorization Algorithm



NUCYNTA
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

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

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

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

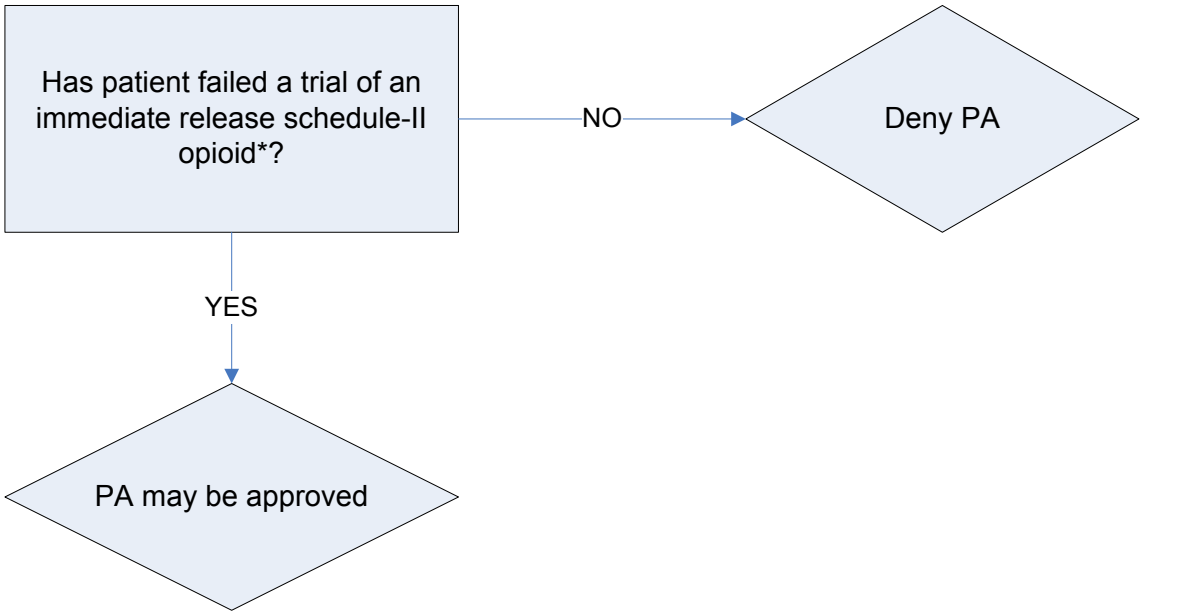
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Nucynta Prior Authorization Algorithm



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

ONFI
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

- **Patient must have a diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS).**
- **Patient must be 2 years of age or older.**

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Onfi	Diagnosis for this request:
Dosing Instructions:	
PHYSICIAN SIGNATURE:	DATE:

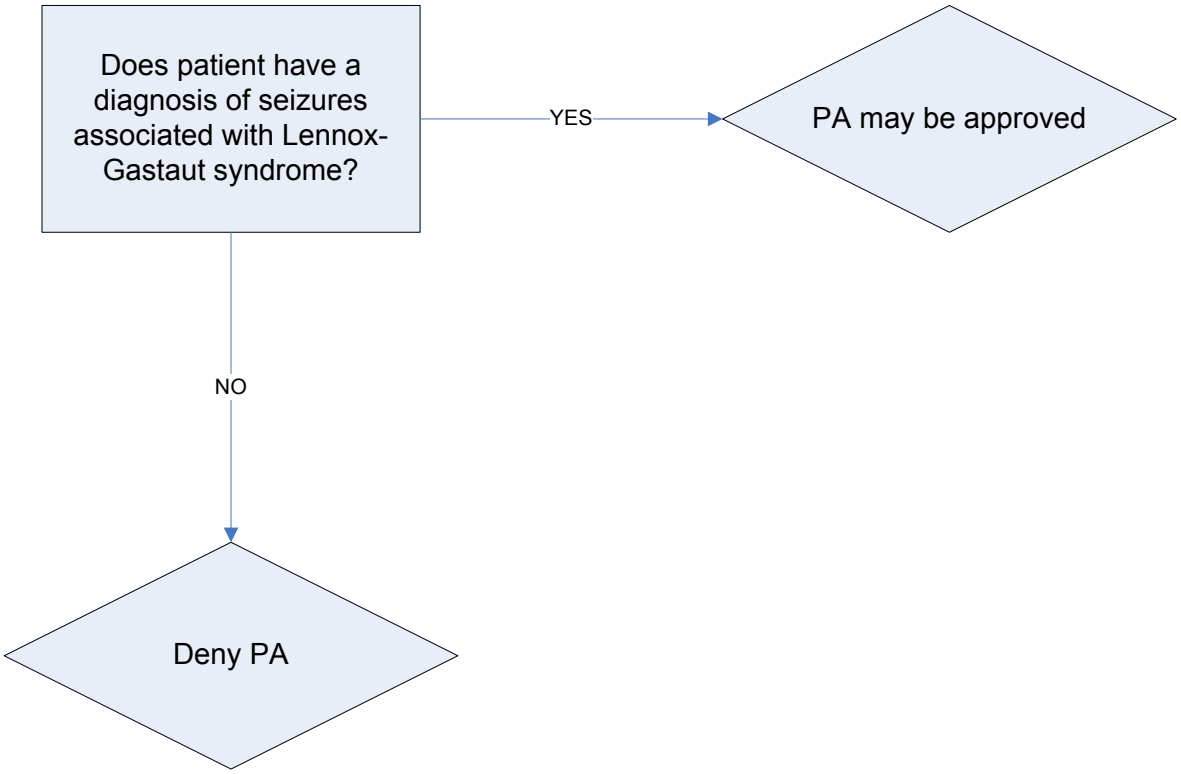
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Onfi Prior Authorization Algorithm



OPHTHALMIC ANTIHISTAMINES
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

SD Medicaid requires that patients receiving a new prescription for Lastacaft, Bepreve, Patanol, and Pataday must first try one of the following:

- **Azelastine, Elestat, Emadine do not require a prior authorization.**

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Lastacaft □ Bepreve □ Pataday	Diagnosis for this request:
PHYSICIAN SIGNATURE:	DATE:

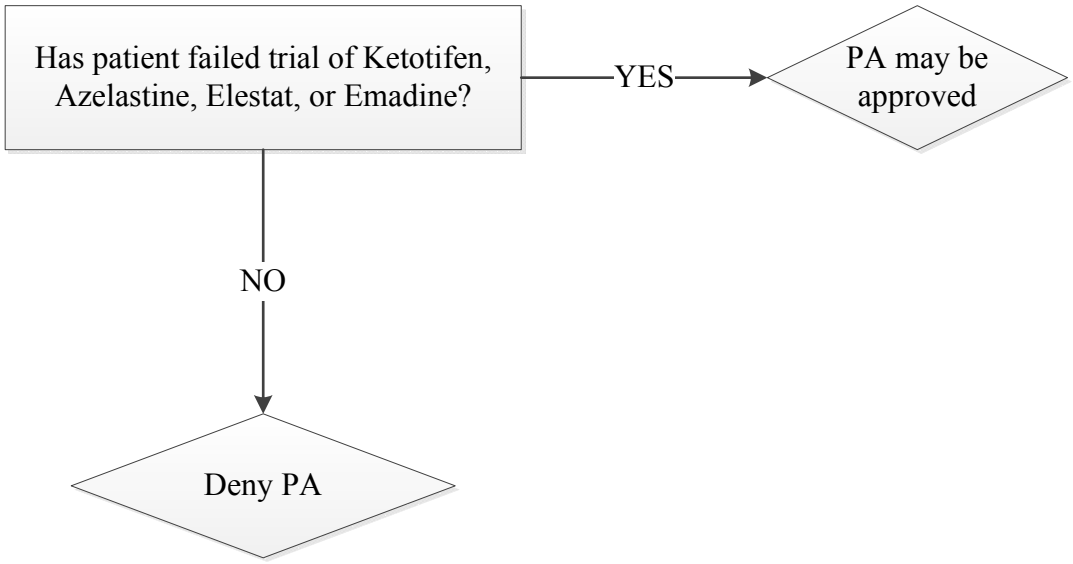
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Ophthalmic Antihistamine Authorization Algorithm



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:

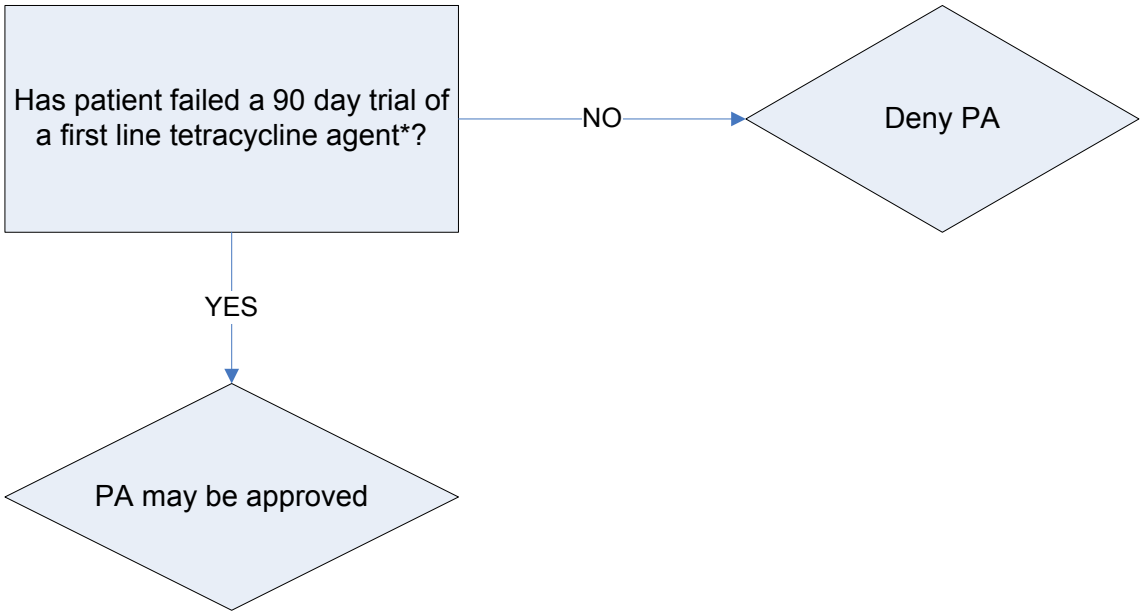
Part IV: PHARMACY INFORMATION

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.

ORAL ANTICOAGULANTS
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

SD Medicaid requires that patients receiving a new prescription for Pradaxa, Xarelto or Eliquis must meet the following criteria:

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

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ **Pradaxa** □ **Xarelto** □ **Eliquis**	Diagnosis for this request:
PHYSICIAN SIGNATURE: DATE:	

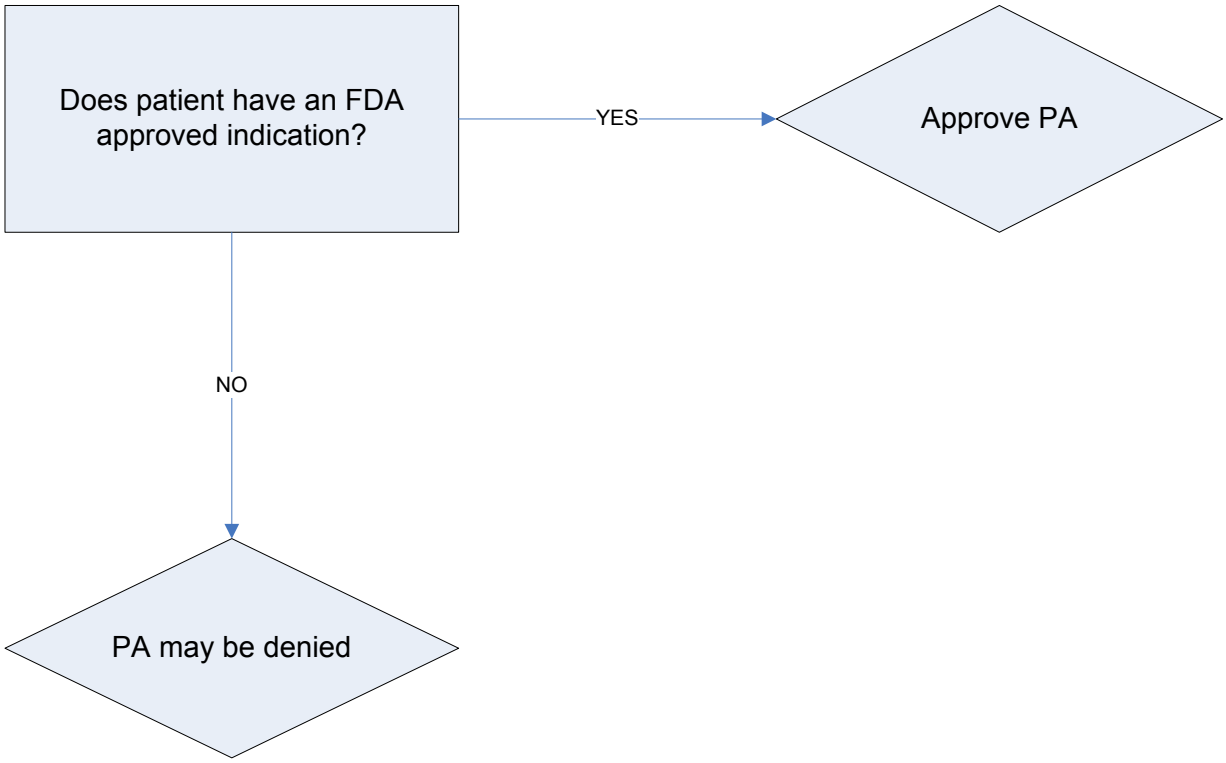
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Oral Anticoagulants Prior Authorization Algorithm



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

ORAVIG
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

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

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

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

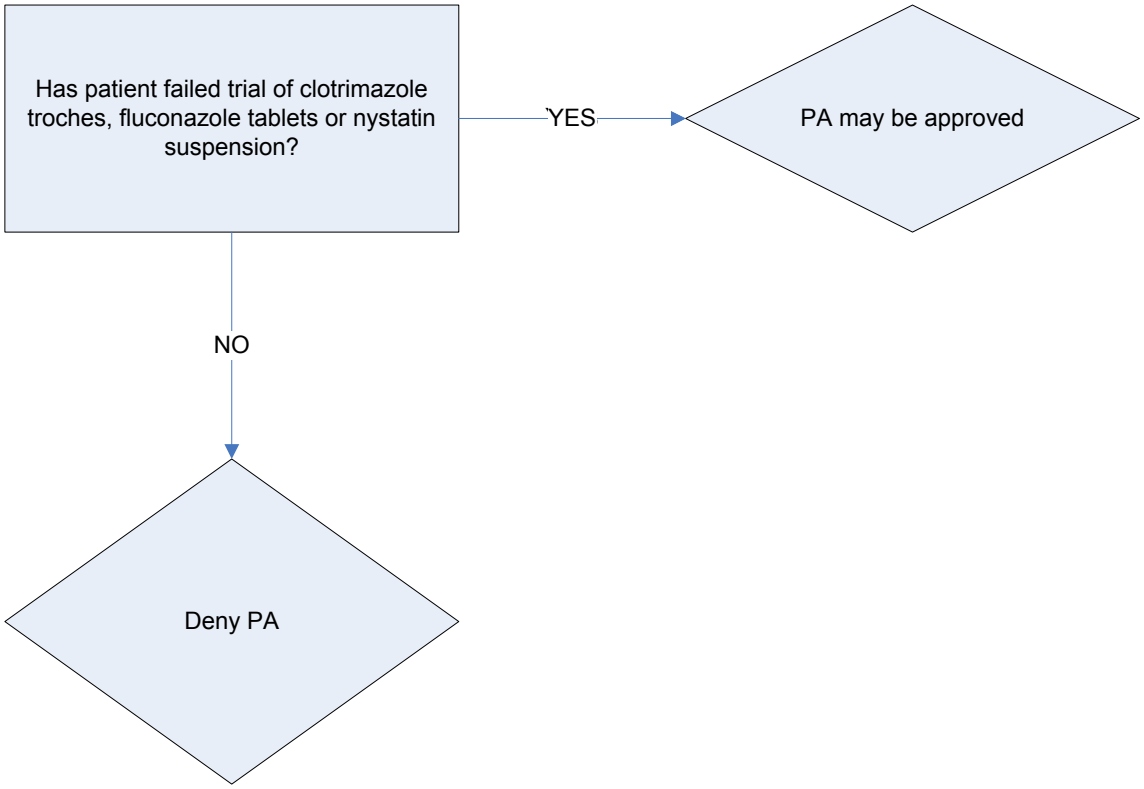
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Oravig Prior Authorization Algorithm



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

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

PEDIATRIC GROWTH HORMONE

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

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

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
RECIPIENT DOB:	

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

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

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

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

IGF-1 Level:_____

Provocative testing: Type_____Results_____Date_____

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

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

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

Please indicate patient's predicted height:

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

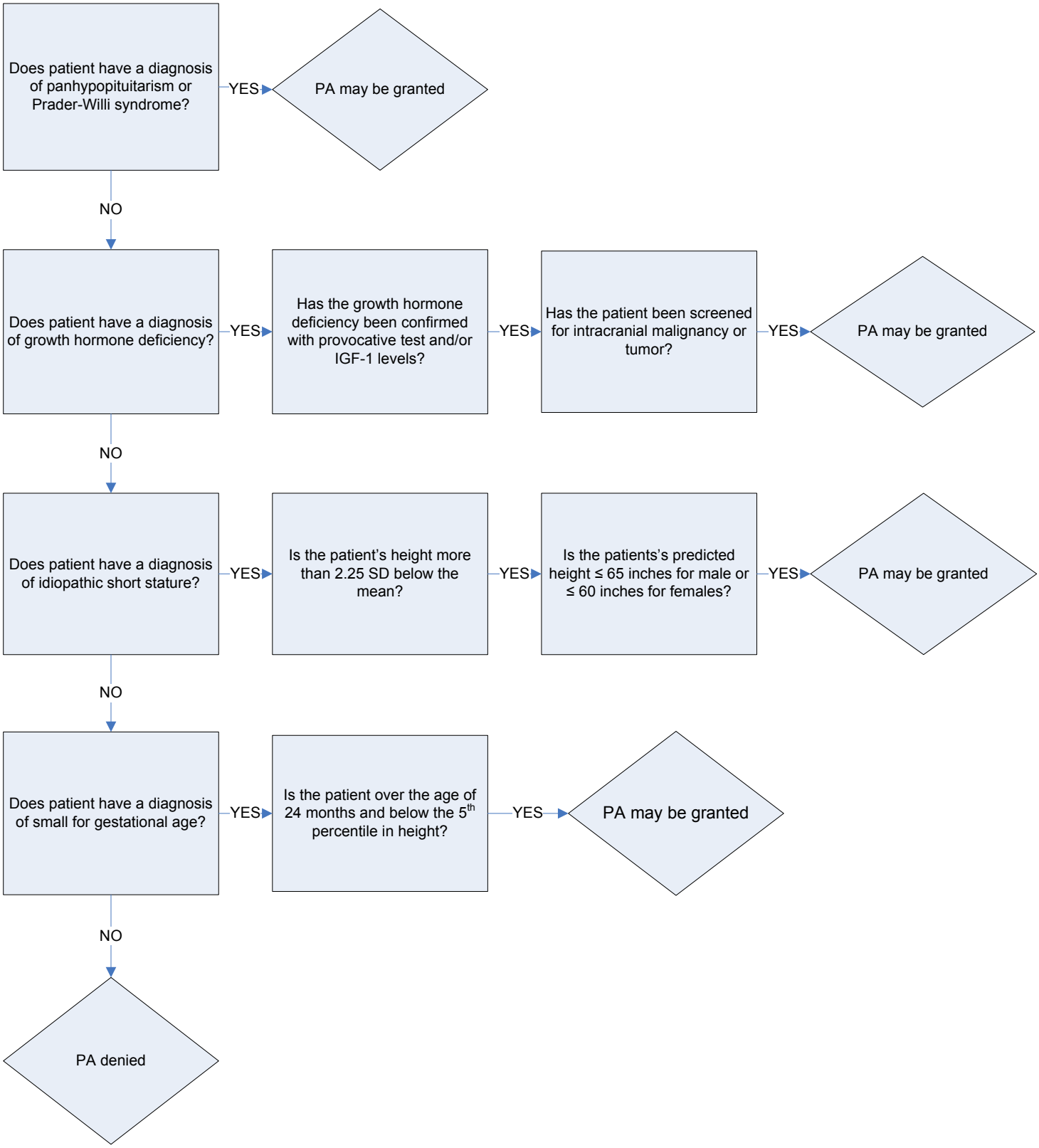
☐ Benign intracranial hypertension ☐ Closed epiphyses ☐ NONE

Physician signature:	Date:

Part IV: PHARMACY INFORMATION

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

South Dakota Department of Social Services
Pediatric Growth Hormone Criteria



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

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

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

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

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

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

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

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

Part III: TO BE COMPLETED BY PHYSICIAN

REQUESTED DRUG:

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

Requested Dosage: (must be completed)

Diagnosis:

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

Qualifications for coverage:

❑ Failed omeprazole, pantoprazole or lansoprazole

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

Dose:

Frequency:

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

❑ Inability to take or tolerate oral tablets (must check a box below):
- ❑ Tube Fed
- ❑ Requires soft food or liquid administration

Other (provide description at right)

Physician Signature:	Date:

Part IV: TO BE COMPLETED BY PHARMACY

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

Part V: FOR OFFICIAL USE ONLY

NDC#:

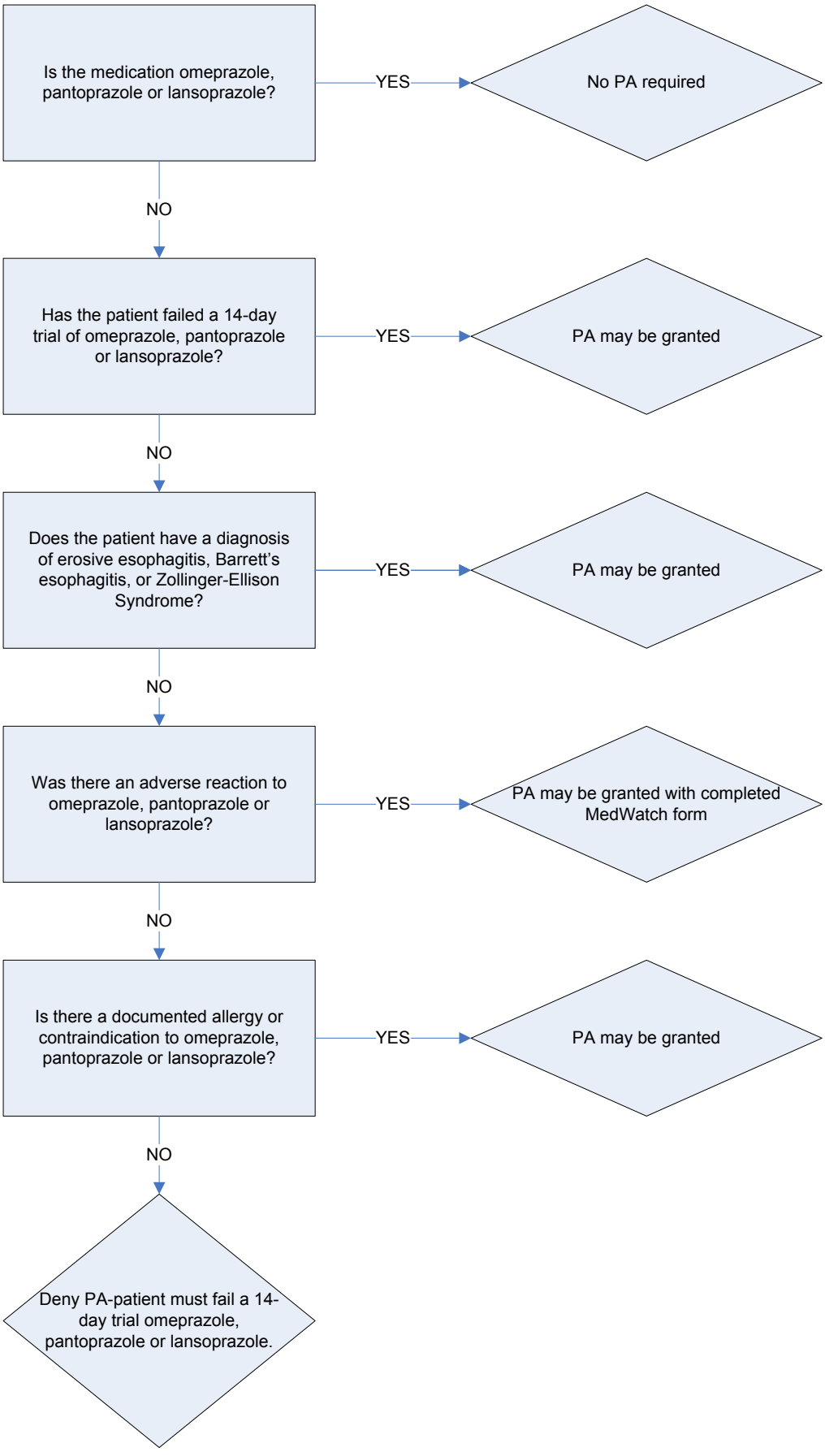
Date: / /

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

Denied (Reasons): To: / /

South Dakota Department of Social Services

Proton Pump Inhibitor Prior Authorization Criteria



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

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

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

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

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

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

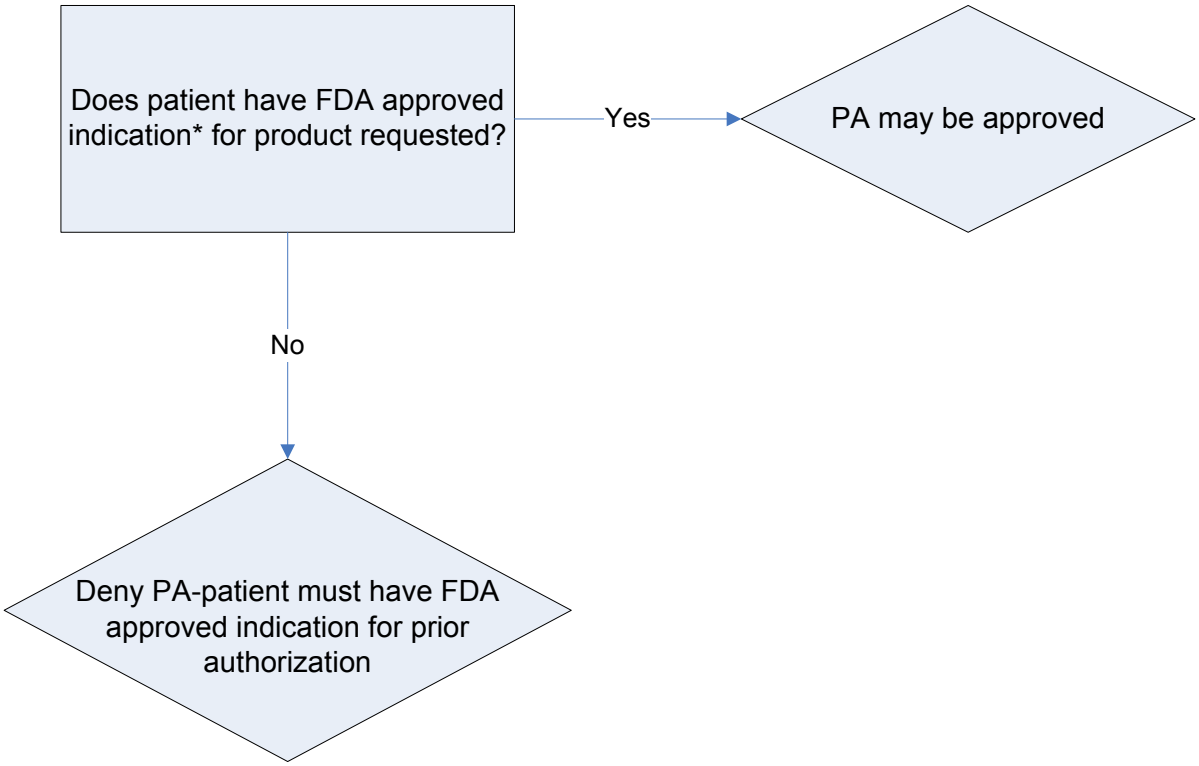
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

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



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

QUALAQUIN
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

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

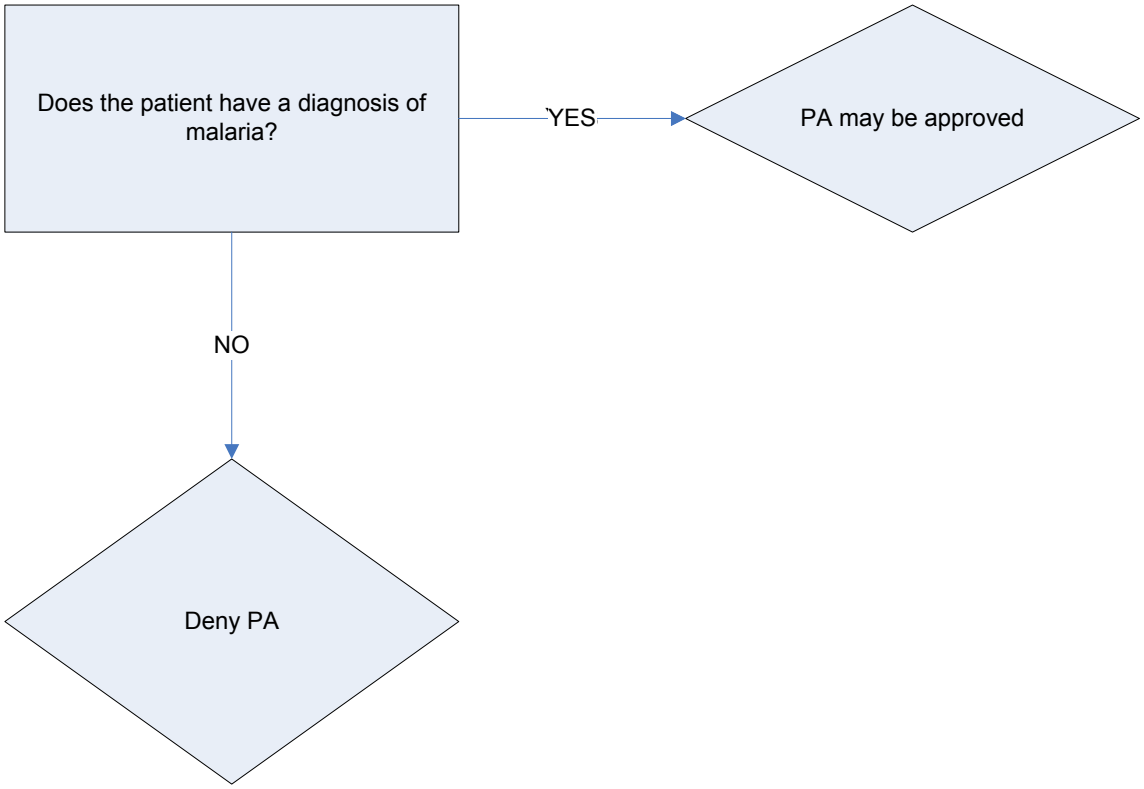
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Qualaquin Prior Authorization Algorithm



RAYOS
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

- Patient must first try generic prednisone.

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

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

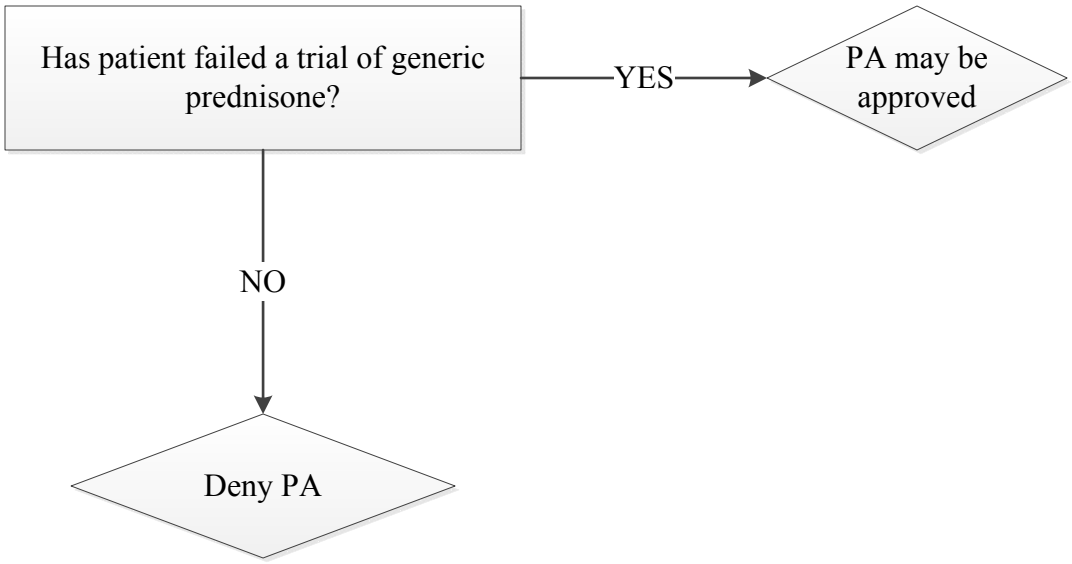
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Rayos Authorization Algorithm



RELISTOR
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

- Patient must be experiencing opioid-induced constipation.
- Patient must have advanced illness receiving palliative care.
- Patient must have tried and failed at least one other laxative.

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ **Relistor**	Diagnosis for this request: Advanced illness:
PHYSICIAN SIGNATURE: DATE:	

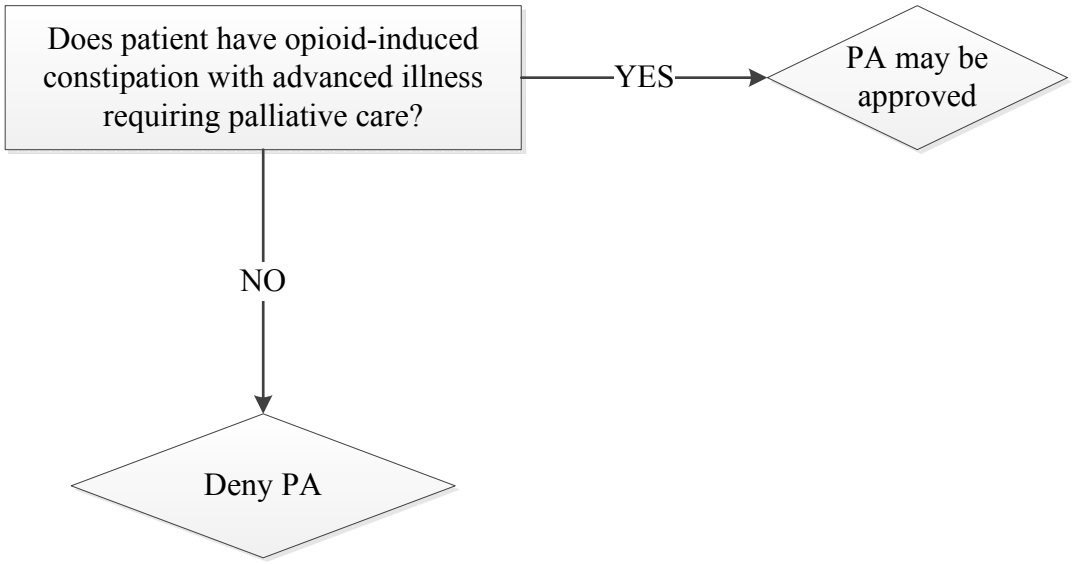
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Relistor Authorization Algorithm



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

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

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

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

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

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

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

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

Part III: TO BE COMPLETED BY PHYSICIAN

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

Qualifications for coverage:

□ Failed carisoprodol therapy	Start Date	End Date	Dose	Frequency

Physician Signature:	Date:

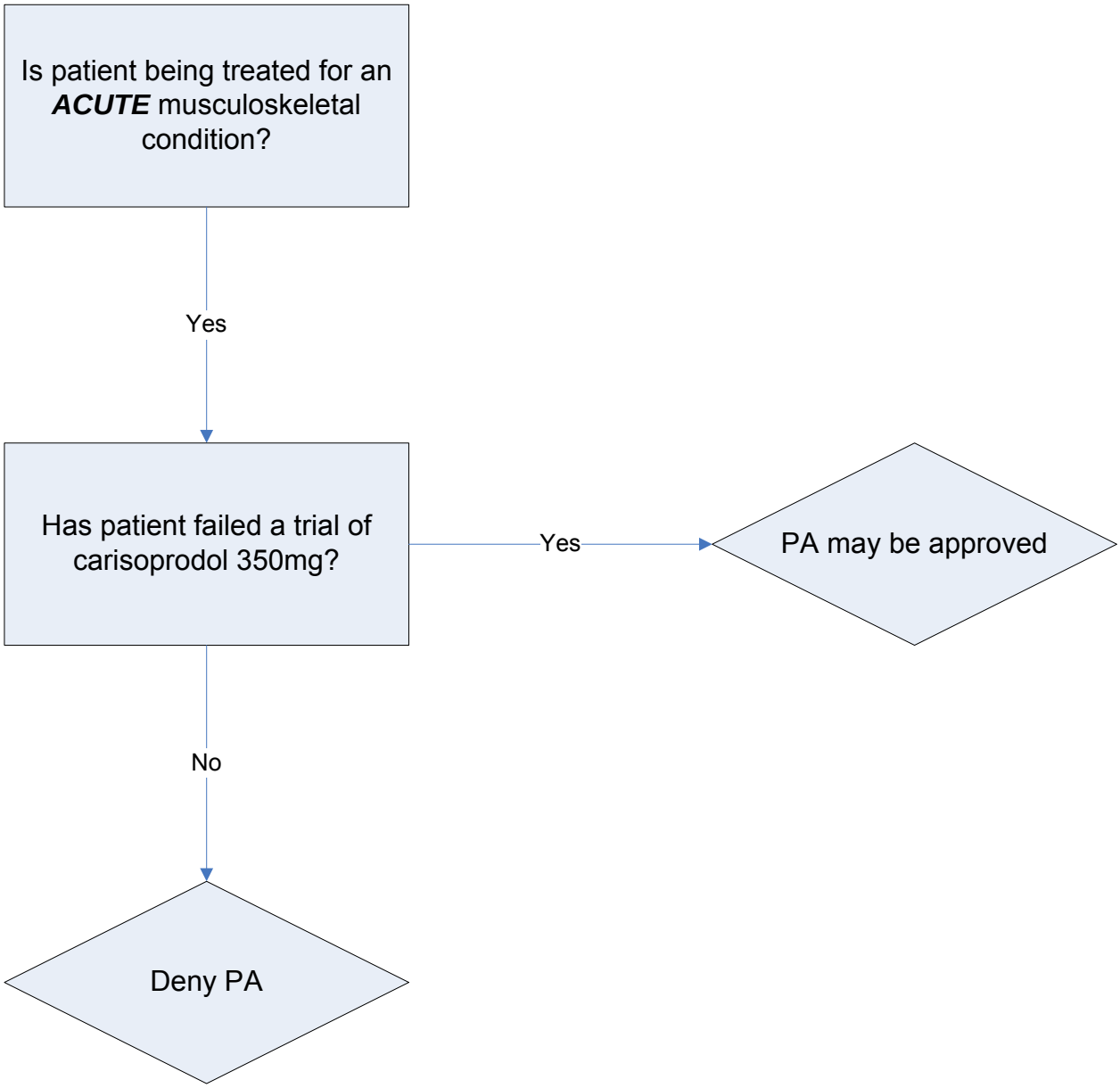
Part IV: TO BE COMPLETED BY PHARMACY

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

Part V: FOR OFFICIAL USE ONLY

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

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



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

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

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

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

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

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

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

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

Part III: TO BE COMPLETED BY PHYSICIAN

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

Qualifications for coverage:

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

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

Physician Signature:	Date:

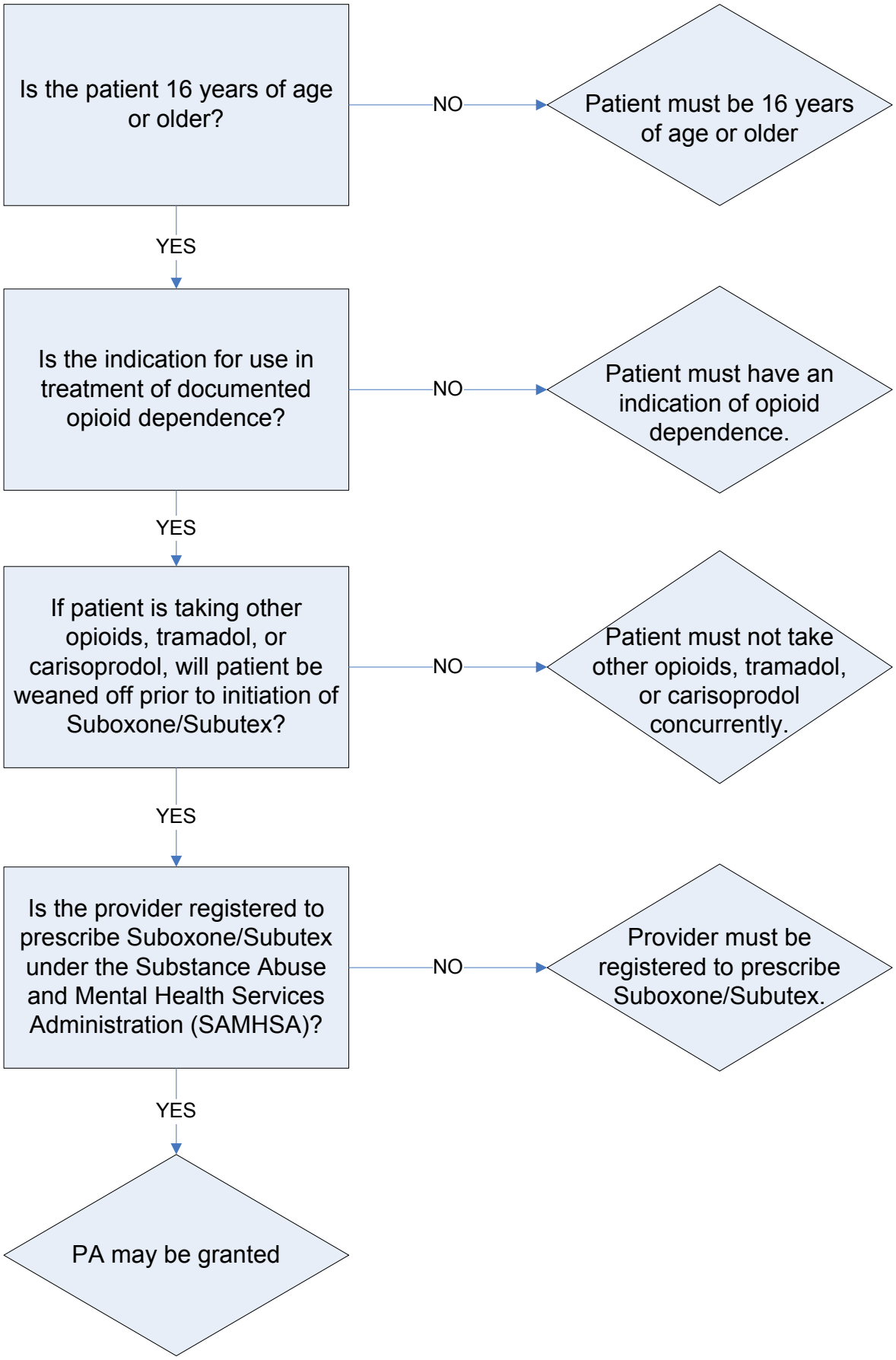
Part IV: TO BE COMPLETED BY PHARMACY

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

Part V: FOR OFFICIAL USE ONLY

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

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



TOPICAL ACNE AGENTS
PRIOR AUTHORIZATION

SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

SD Medicaid requires that patients receiving a new prescription for a branded topical acne agent must meet the following criteria:

- **Patients must first try and fail a generic topical acne agent (erythromycin, benzoyl peroxide, clindamycin, tretinoin, sodium sulfacetamide/sulfur)**

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage:	Diagnosis for this request:
Failed therapy:	Dosage:
	Frequency:
PHYSICIAN SIGNATURE:	DATE:

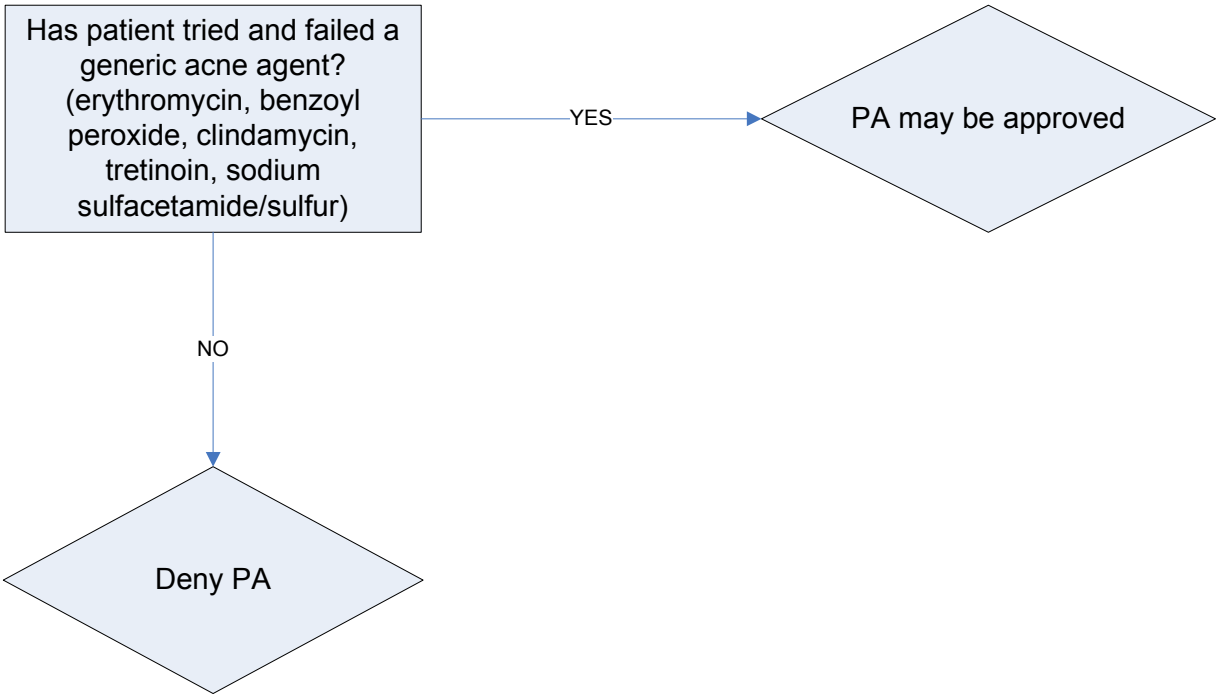
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

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



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:

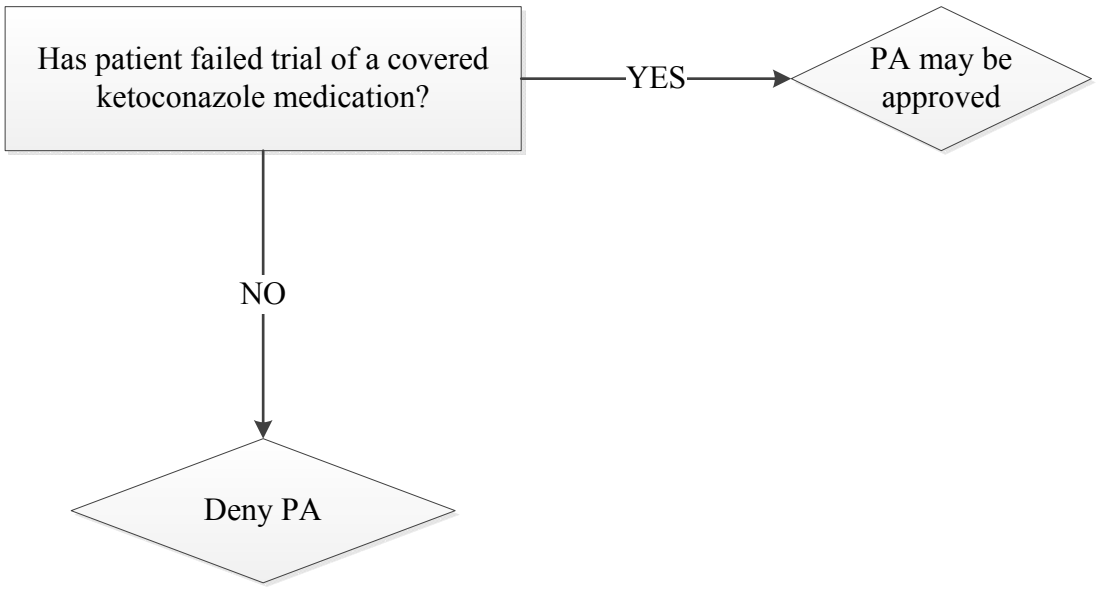
Part IV: PHARMACY INFORMATION

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



Serotonin (5-HT$_1$) Receptor Agonists
TRIPTAN PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

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

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

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

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

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

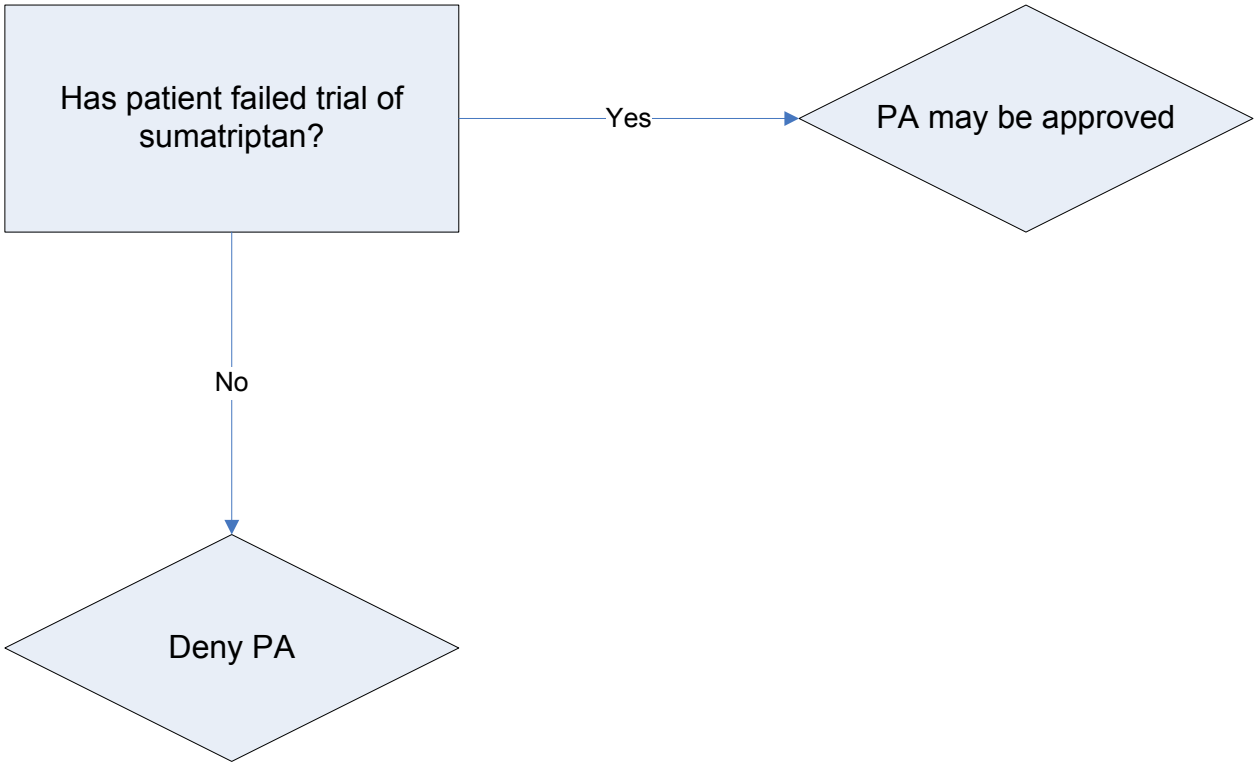
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

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



TYSABRI
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

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

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

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

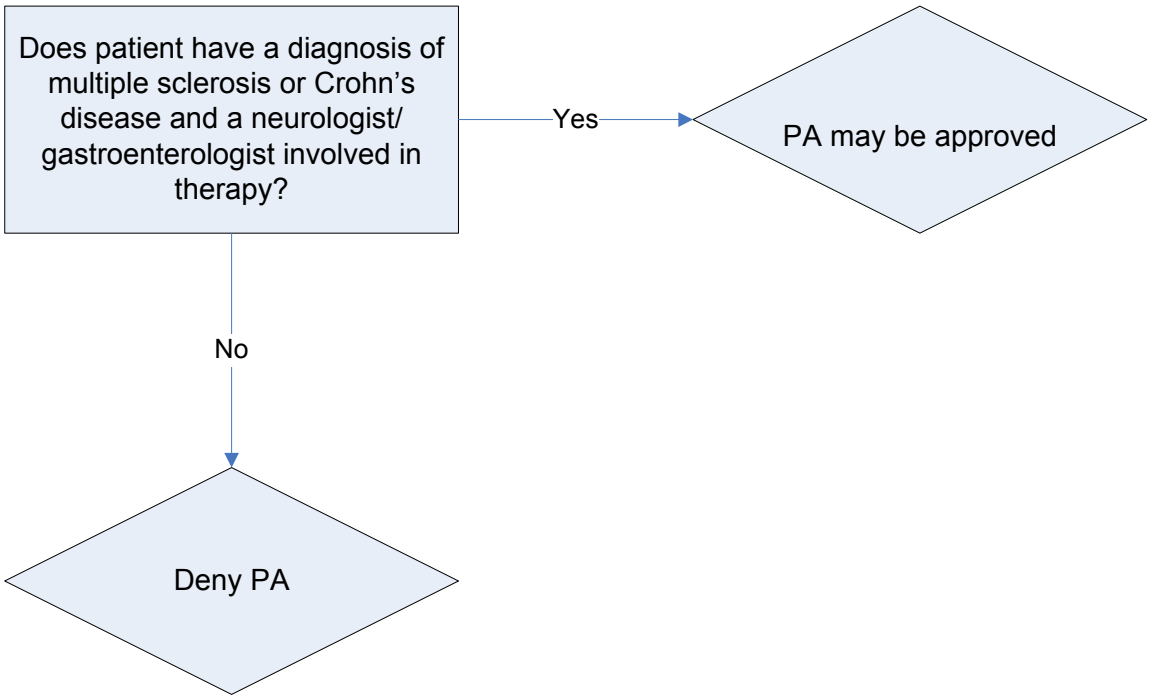
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Tysabri Prior Authorization Algorithm



ULORIC
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

SD Medicaid requires that patients receiving a new prescription for Uloric must try allopurinol as first line therapy or have documented renal/hepatic dysfunction or intolerance of allopurinol.

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

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

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

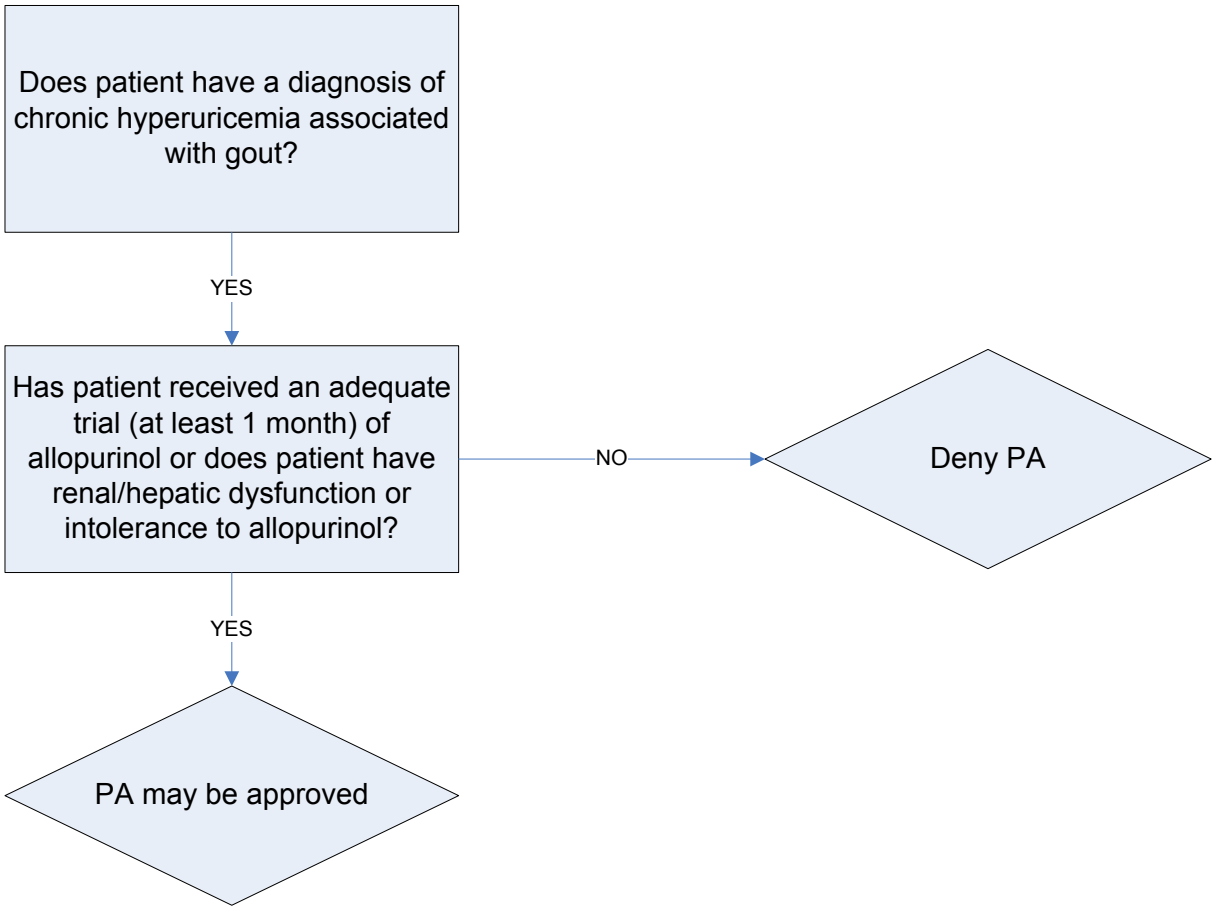
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Uloric Prior Authorization Algorithm



Allopurinol does not require a prior authorization

ULTRAM ER/RYZOLT PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

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

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

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

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Dosage: (must be completed)

Diagnosis for this request:

Qualifications for coverage:

❑ Patient is currently stable on Ultram ER/Ryzolt

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

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

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

Physician Signature: Date:

Part IV: PHARMACY INFORMATION

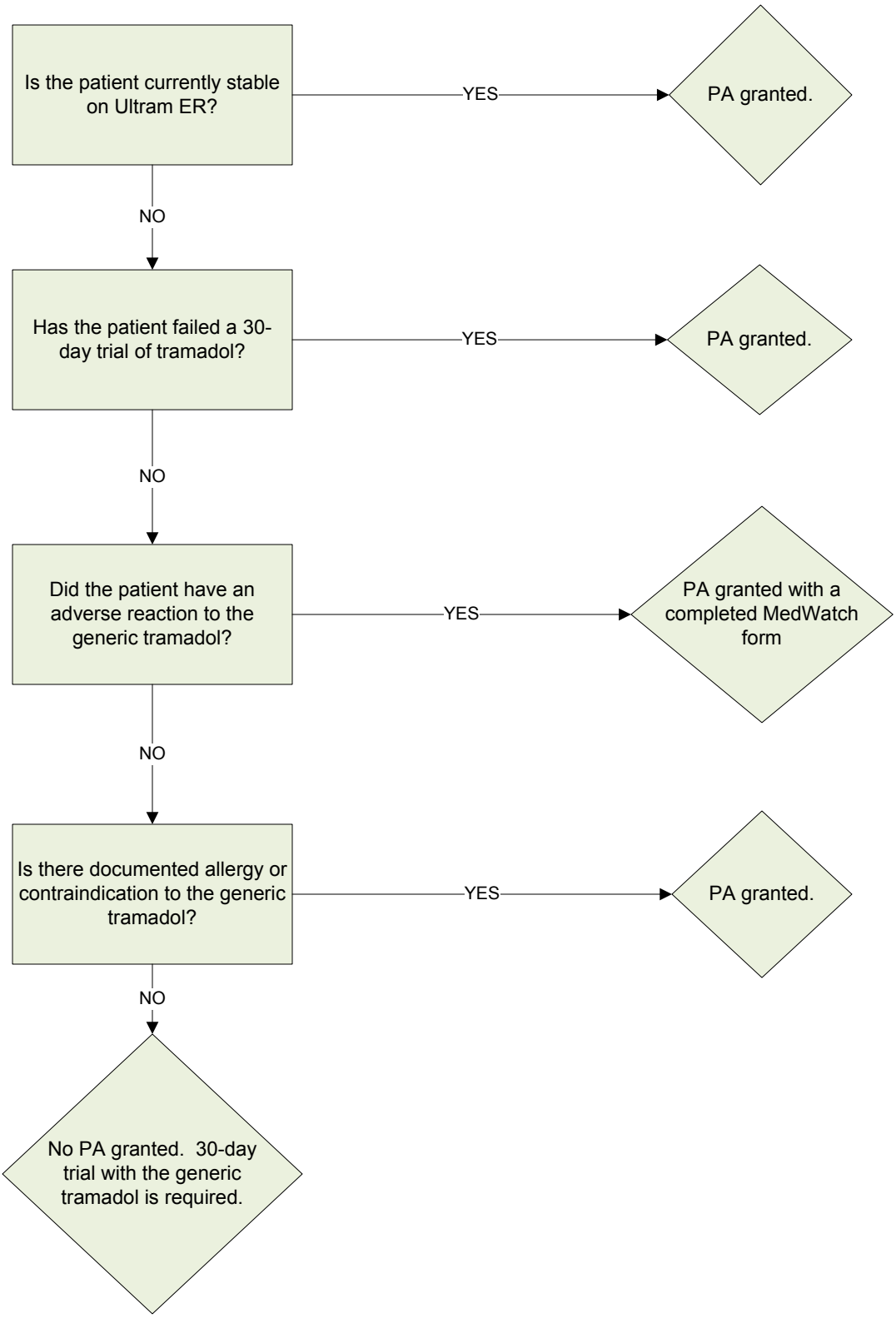
PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services

Ultram ER and Ryzolt
Criteria Algorithm



VUSION PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

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

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

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

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

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

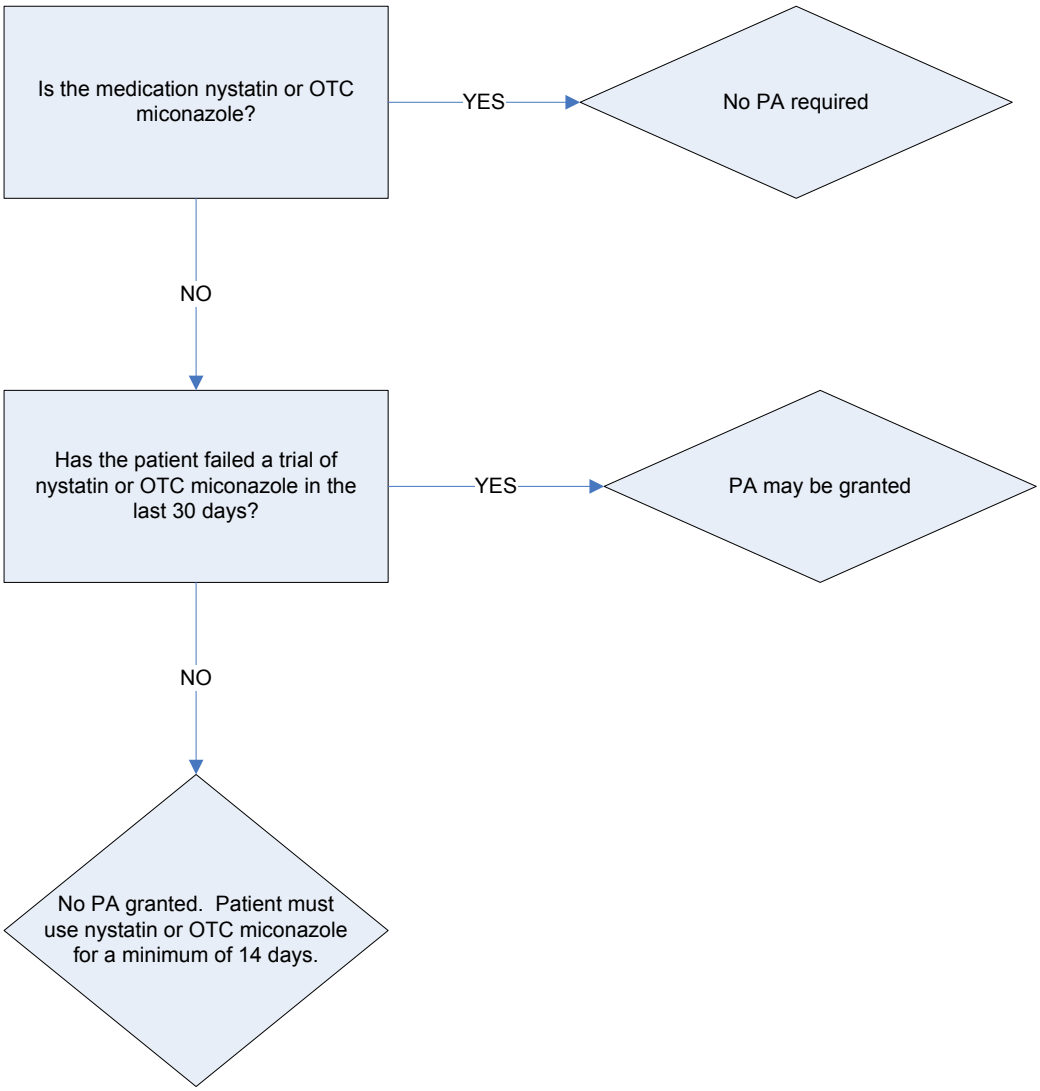
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Vusion Prior Authorization Criteria



XIFAXAN
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

- Patient must have a diagnosis of travelers' diarrhea (TD) caused by noninvasive strains of E.coli and be 12 years of age or older.
- Patient must have a diagnosis of hepatic encephalopathy (HE) and be ≥ 18 years of age and failed a trial of lactulose.
- TD usual dose – 200mg three times a day for 3 days
- HE usual dose – 550mg twice a day (1100mg/day)

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ **Xifaxan 200mg** □ **Xifaxan 550mg**	Diagnosis for this request: Date of lactulose trial for Xifaxan 550mg:
PHYSICIAN SIGNATURE: DATE:	

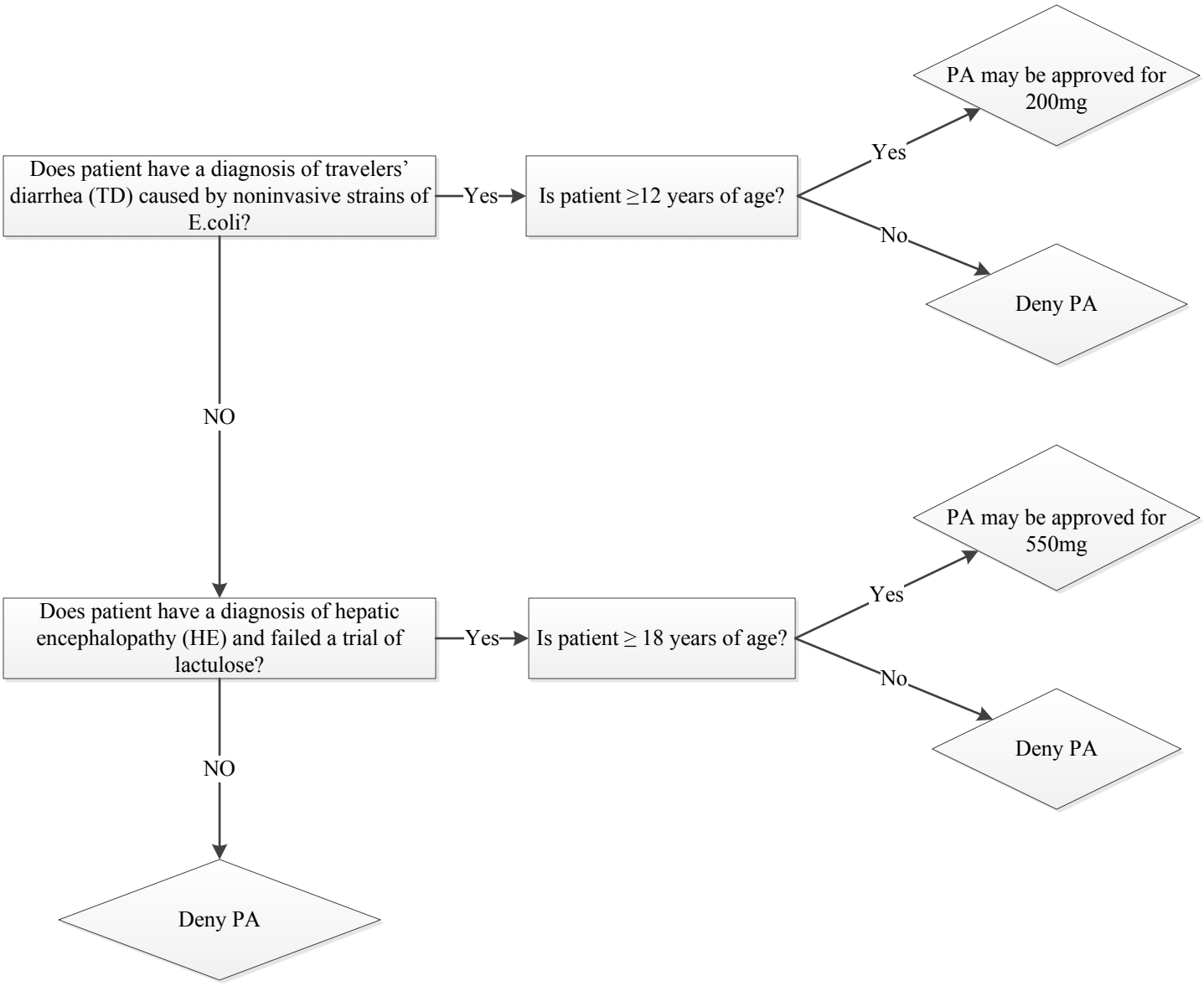
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Xifaxan Authorization Algorithm



XOLAIR PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

SD Medicaid requires that patients receiving a prescription for Xolair must have moderate to severe persistent asthma with a positive skin test or in vitro reactivity to a perennial aeroallergen and symptoms inadequately controlled with inhaled corticosteroids.

- **Xolair will be covered for patients with a diagnosis of moderate to severe persistent asthma who have elevated serum levels of IgE.**

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

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

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: (must be completed)	**Specialist involved in therapy:**
	Diagnosis for this request:

Qualifications for coverage:

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

_____

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

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

Physician Signature: Date:

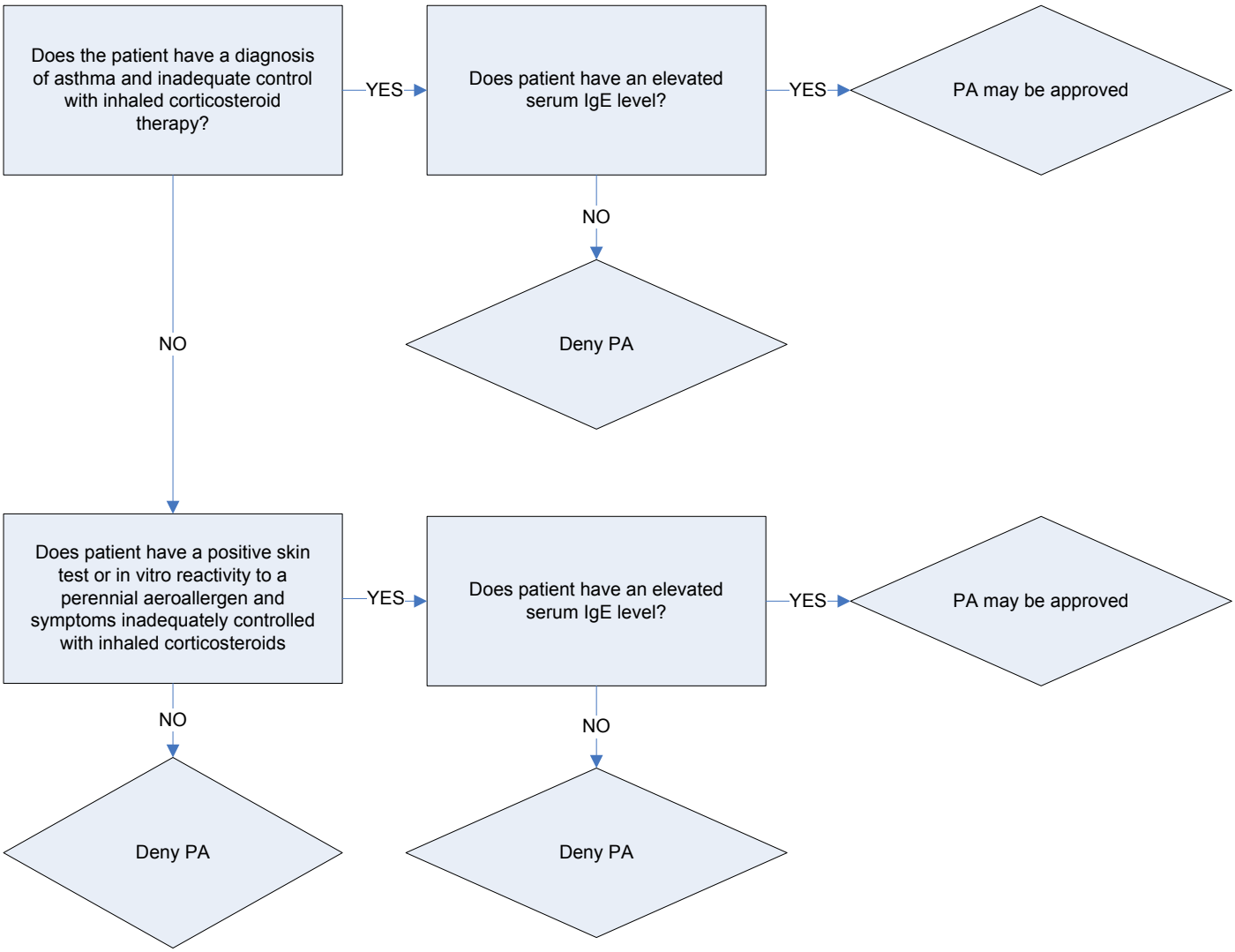
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Xolair Prior Authorization Criteria



XYREM PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

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

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

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

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

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

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

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

Part III: TO BE COMPLETED BY PHYSICIAN:

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

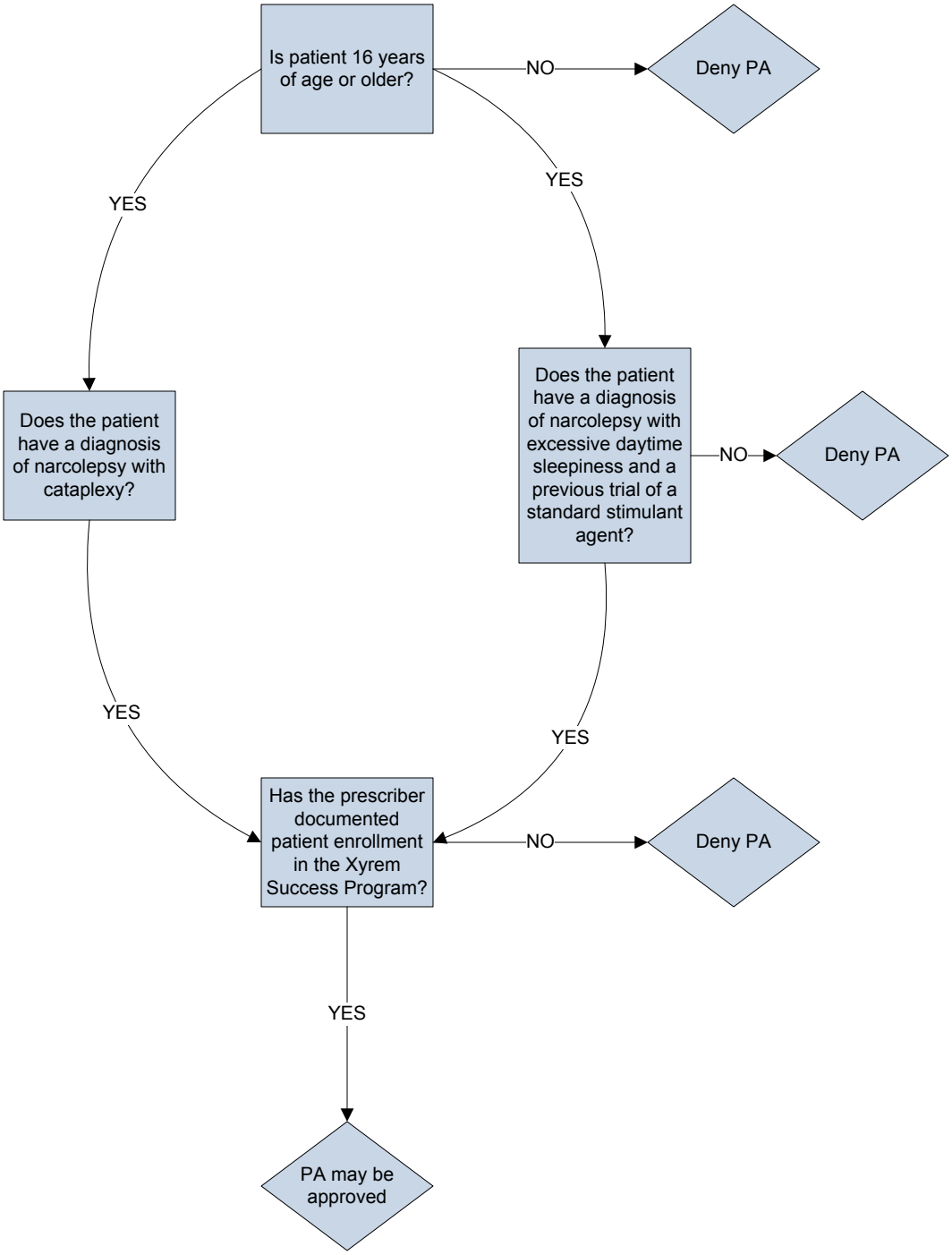
Part IV: PHARMACY INFORMATION

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

Part V: FOR OFFICIAL USE ONLY

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

South Dakota Department of Social Services
Xyrem Prior Authorization Criteria



South Dakota Department of Social Services
Pharmacotherapy Review
Medications for
Attention Deficit Hyperactivity Disorder (ADHD)
March 8, 2013

I. Overview

ADHD is a severe, debilitating condition diagnosed in approximately 8.4% (5.2 million) of youth aged 3-17 years. Children with ADHD are usually diagnosed between the ages of 6 to 12. Suboptimal academic performance is often the reason for initial screening. A diagnosis of ADHD is subjective in nature, with the provider looking for symptoms of inattention, hyperactivity, and impulsivity: symptoms that are frequent and severe enough to interfere with the child's, and often the family's, ability to lead a normal life. These children, left undiagnosed or untreated, are at higher risk of self-injury, depression, low self-esteem, delinquent behavior, antisocial personality traits, substance abuse and other comorbidities.

Most medications for Attention Deficit Hyperactivity Disorder (ADHD) are CNS stimulants, which are thought to work by blocking reuptake of norepinephrine and dopamine in the presynaptic neurons and increasing release of these neurotransmitters into the extraneural space. There are three non-stimulant medications also approved to treat ADHD, atomoxetine (Strattera®), guanfacine (Intuniv®), and clonidine (Kapvay®). Strattera is classified as a norepinephrine reuptake inhibitor and works by selectively inhibiting presynaptic norepinephrine transporters. Intuniv is classified as a selective $alpha_{2A}$-adrenergic receptor agonist that reduces sympathetic nerve impulses to the heart and blood vessels resulting in a decrease in peripheral vascular resistance and a reduction in heart rate. Kapvay is a centrally acting $alpha_2$-adrenergic agonist.

Pharmacotherapy, along with behavior therapy and counseling, can help those patients diagnosed with ADHD lead a normal and productive life. For many years, CNS stimulants have been considered first-line therapy for the treatment of ADHD. With the approval of atomoxetine in late 2002, patients now have another treatment option.

II. Current Treatment Guidelines

American Academy of Pediatrics Clinical Practice Guideline: ADHD Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents (2011)

1. The primary care clinician should initiate an evaluation for ADHD for any child 4 through 18 years of age who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity.
2. To make a diagnosis of ADHD, the primary care clinician should determine that Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition criteria have been met. Information should be obtained from parents, guardians, teachers, and other school and mental health clinicians.
3. In the evaluation of a child for ADHD, the primary care clinician should include assessment for other conditions that might coexist with ADHD, including emotional or behavioral, developmental, and physical conditions.
4. The primary care clinician should recognize ADHD as a chronic condition and, therefore, consider children and adolescents with ADHD as children and youth with special health care needs. Management of children and youth with special health care needs should follow the principles of the chronic care model and the medical home.
5. Recommendations for treatment of children and youth with ADHD vary depending on the patient's age:

a. For preschool-aged children (4-5 years of age), the primary care clinician should prescribe evidence-based parent and/or teacher-administered behavior therapy as the first line of treatment and may prescribe methylphenidate if the behavior interventions do not provide significant improvement and there is moderate-to-severe continuing disturbance in the child's function. In areas where evidence-based behavioral treatments are not available, the clinician needs to weigh the risks of starting medication at an early age against the harm of delaying diagnosis and treatment.
b. For elementary school-aged children (6-11 years of age), the primary care clinician should prescribe FDA approved medications for ADHD and/or evidence-based parent and/or teacher-administered behavior therapy as treatment for ADHD, preferably both. The evidence is particularly strong for stimulant medications and sufficient but less strong for atomoxetine, extended-release guanfacine, and extended-release clonidine (in that order).
c. For adolescents (12-18 years of age), the primary care clinician should prescribe FDA approved medications for ADHD with the assent of the adolescent and may prescribe behavior therapy as treatment for ADHD, preferably both.

6. The primary care clinician should titrate doses of medication for ADHD to achieve maximum benefit with minimum adverse effects.

American Academy of Child and Adolescent Psychiatry (AACAP)
Practice Parameter for the Use of Stimulant Medication in the Treatment of Children, Adolescents, and Adults (2007)

1. The first agent tried should have FDA approval for the treatment of ADHD; possible agents would be dextroamphetamine, methylphenidate (MPH), mixed salts of amphetamine, and atomoxetine.
2. Stimulants have been proven in many clinical trials to be highly effective in the treatment of ADHD.
3. The physician may choose either MPH or amphetamines, as data suggests equal efficacy between the two stimulant types.
4. Longer-acting formulations may be used as initial treatment and are associated with greater compliance. Physicians do not need to initiate treatment with the short-acting forms, or use them to titrate to the appropriate dosage of the long-acting forms. Short-acting forms may be used to initiate therapy in low-weight children where long-acting forms may not be available in the necessary smaller doses.
5. Once a medication is initiated, the dose should be titrated up every 1 to 3 weeks until the maximum dose for the stimulant is reached, the symptoms of ADHD remit, or side effects prevent further titration.
6. It is recommended that the patient be in contact with the physician during the titration period and visit the physician after 1 month of therapy to assess effectiveness and determine long-term therapy plans.
7. Patients may show an initial response rate of up to 85% when both stimulant forms are tried versus the response rate of only 65%-75% observed in clinical trials when patients were treated with only one stimulant. Therefore, if a patient fails one stimulant, it is recommended that another be tried.
8. For the treatment of preschoolers, the available evidence suggests that titration of stimulants be done slowly and that lower doses may be effective. This may be due to slower metabolism of methylphenidate (MPH) in preschoolers.
9. In studies published comparing atomoxetine to stimulants, greater efficacy was seen in those patients treated with stimulants.
10. Atomoxetine may be used as a first-line agent in patients with an active substance abuse problem, comorbid anxiety, tics, or in those who experience severe side effects while taking stimulants.

III. Drug Treatment for ADHD

Generic Name	Brand Name	Available Strengths	Initial Dosage
Amphetamines			
Amphetamine aspartate, amphetamine sulfate, dextroamphetamine saccharate, and dextroamphetamine sulfate	Adderall, Adderall XR, various generics	5, 7.5, 10, 12.5, 15, 20, 30 mg tablet; 5, 10, 15, 20, 25, 30 mg extended-release capsule	Adderall: (3-5 years) 2.5mg daily; (≥ 6 years) 5mg once or twice daily. Adderall XR: (6-17 years) 10 mg once daily; (≥ 18 years) 20 mg once daily.
Dextroamphetamine	Dexedrine, Procentra, various generics	5, 10 mg tablet; 5, 10, 15 mg extended-release capsule; 5mg/ml solution	Dextroamphetamine IR: (3-5 years) 2.5 mg once daily; (≥6 years) 5 mg once or twice daily. Dextroamphetamine ER: (≥ 6 years) 5mg once or twice daily. Procentra: (3-5 years) 2.5 mg once daily; (≥6 years) 5mg once or twice daily.
Lisdexamfetamine	Vyvanse	20, 30, 40, 50, 60, 70 mg capsule	(≥6 years) 30 mg daily in the morning.
Methamphetamine	Desoxyn, generic	5 mg tablet	(≥ 6 years) 5 mg once or twice daily.
Non-amphetamines			
Dexmethylphenidate	Focalin, Focalin XR	2.5, 5, 10 mg tablet; 5, 10, 15, 20, 25, 30, 35, 40 mg extended-release capsule	Focalin: (≥ 6 years) 2.5 mg twice daily. Focalin XR: (6-17 years) 5 mg once daily; (≥ 18 years) 10 mg once daily.
Methylphenidate	Concerta, Daytrana, Metadate CD, Metadate ER, Methylin, Quillivant XR, Ritalin, Ritalin LA, Ritalin SR	18, 27, 36, 54 mg extended-release tablet (osmotic release); 10, 15, 20, 30 mg/9 hr transdermal patch; 10, 20, 30, 40, 50, 60 mg extended-release capsule; 10, 20 mg extended-release tablet; 2.5, 5, 10 mg chewable tablet; 5, 10 mg/5 ml solution; 25 mg/5ml solution; 5, 10, 20 mg tablet	Concerta: (6-17 years) 18 mg once daily; (≥ 18 years) 18-36 mg once daily. Daytrana: (≥ 6 years) 10 mg patch worn nine hours daily. Metadate CD, Ritalin LA: (≥ 6 years) 20 mg once daily. Metadate ER, Ritalin SR: (≥ 6 years) ER and SR tablets may be used

Generic Name	Brand Name	Available Strengths	Initial Dosage
			in place of IR tablets when the 8 hour dosage of ER and SR tablets corresponds to the titrated 8 hour dosage of IR tablets. Methylin, Ritalin: (≥ 6 years) 5 mg twice daily.
Non-Stimulants			
Atomoxetine	Strattera	10, 18, 25, 40, 60, 80, 100 mg capsule	≥ 6 years and ≤ 70 kg: 0.5 mg/kg/day. ≥ 6 years and ≥ 70 kg and adults: 40 mg/day.
Clonidine	Kapvay	0.1 mg extended-release tablet	≥ 6 years: 0.1 mg at bedtime.
Guanfacine	Intuniv	1, 2, 3, 4 mg extended-release tablet	≥ 6 years: 1 mg once daily.

IV. Contraindications

Amphetamines

- Advanced arteriosclerosis
- Symptomatic cardiovascular disease
- Moderate to severe hypertension
- Hyperthyroidism
- Known hypersensitivity or idiosyncrasy to the sympathomimetic amines
- Glaucoma
- Agitated states
- History of drug abuse
- During or within 14 days following administration of a monoamine oxidase inhibitor (MAOI)

Methylphenidate and Dexmethylphenidate

- Marked anxiety, tension, and agitation
- Glaucoma
- Patients with motor tics or a family history or diagnosis of Tourette syndrome
- During treatment with a MAOI and within a minimum of 14 days following discontinuation of an MAOI
- **Metadate CD, Metadate ER, and Methylin ER are contraindicated in patients with severe hypertension, angina pectoris, cardiac arrhythmias, heart failure, recent myocardial infarction (MI), hyperthyroidism or thryotoxicosis.**

Atomoxetine

- Narrow-angle glaucoma
- Use with a MAOI or within 2 weeks of discontinuing a MAOI
- Pheochromocytoma or a history of pheochromocytoma
- Severe cardiovascular disorders (e.g., whose condition would be expected to deteriorate if they experience increases in blood pressure or heart rate that could be clinically important)

Guanfacine ER

- Hypersensitivity to guanfacine or any components of the product

Clonidine ER

- Known hypersensitivity to clonidine

V. Black Box Warnings

Black Box Warning for Amphetamines

Amphetamines have a high potential for abuse. Administration of amphetamines for prolonged periods of time may lead to drug dependence and must be avoided. Particular attention should be paid to the possibility of subjects obtaining amphetamines for non-therapeutic use or distribution to others and the drugs should be prescribed or dispensed sparingly. Misuse of amphetamines may cause sudden death and serious cardiovascular adverse events.

Black Box Warning for Methylphenidate and Dexmethylphenidate

Give methylphenidate cautiously to emotionally unstable patients such as those with a history of drug dependence or alcoholism, because such patients may increase dosage at their own initiative.

Methylphenidate and dexmethylphenidate should be given cautiously to patients with a history of drug dependence or alcoholism. Chronic abusive use can lead to marked tolerance and psychological dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during withdrawal from abusive use since severe depression may occur. Withdrawal following chronic therapeutic use may unmask symptoms of the underlying disorder that may require follow-up.

Black Box Warning for Atomoxetine

Atomoxetine increased the risk of suicidal ideation in short-term studies in children or adolescents with Attention-Deficit/Hyperactivity Disorder (ADHD). Anyone considering the use of atomoxetine in a child or adolescent must balance this risk with the clinical need. Co-morbidities occurring with ADHD may be associated with an increase in the risk of suicidal ideation and/or behavior. Patients who are started on therapy should be monitored closely for suicidality (suicidal thinking and behavior), clinical worsening, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Atomoxetine is approved for ADHD in pediatric and adult patients. Atomoxetine is not approved for major depressive disorder.

Pooled analyses of short-term (6 to 18 weeks) placebo-controlled trials in children and adolescents (a total of 12 trials involving over 2,200 patients, including 11 trials in ADHD and 1 trial in enuresis) have revealed a greater risk of suicidal ideation early during treatment in those receiving atomoxetine compared to placebo. The average risk of suicidal ideation in patients receiving atomoxetine was 0.4% compared with none in placebo-treated patients. No suicides occurred in these trials.

VI. Warnings and Precautions

Amphetamines

- Cardiovascular effects
- CNS effects
- Tolerance
- Drug dependence
- Growth inhibition
- Hypertension
- Potentially hazardous tasks
- Tics
- Seizures

- Fatigue
- Visual disturbance
- Tartrazine sensitivity

Methylphenidate and Dexmethylphenidate

- Serious cardiovascular effects
- Contact sensitization (transdermal)
- External heat (transdermal)
- Depression
- Fatigue
- Long-term suppression of growth
- Psychiatric effects
- Seizures
- Visual disturbances
- GI obstruction (Concerta only)
- Phenylketonurics
- Agitation
- Drug abuse and dependence
- Carcinogenesis

Atomoxetine

- Suicidal ideation
- Hepatic effects
- Cardiovascular effects
- Emergence of new psychotic or manic symptoms
- Comorbid bipolar disorder
- Aggressive behavior or hostility
- Urinary effects
- Priapism
- Effects on growth
- Narrow-angle glaucoma
- Pheochromocytoma
- Hypersensitivity reactions
- Drug abuse and dependence
- Hazardous tasks

Guanfacine ER

- Cardiovascular effects
- Sedation
- Rebound
- Renal function impairment
- Hepatic function impairment
- Special risk patients (severe coronary insufficiency, recent MI, cerebrovascular disease, or chronic renal or hepatic failure)
- Hazardous tasks

Clonidine ER

- Withdrawal
- Cardiovascular effects
- Perioperative use
- CNS effects
- Drug abuse
- Hypersensitivity reactions

- Renal function impairment
- Special risk patients (severe coronary insufficiency, conduction disturbances, recent MI, cerebrovascular disease, or chronic renal failure)
- Hazardous tasks

VII. ADHD Medication Drug Interactions

Clinically important drug interactions exist for the ADHD medications with certain, important differences among the classes. Each of the medications in this class should be used cautiously with antihypertensives, tricyclic antidepressants, and MAO inhibitors (can result in hypertensive crisis).

Amphetamines

- Furazolidone: Increased sensitivity to amphetamines may occur-reduce amphetamine dose accordingly.
- Haloperidol: Blocks dopamine receptors, inhibiting the central stimulant effects of amphetamines.
- Urinary acidifying agents (e.g., ammonium chloride, sodium acid phosphate): The elimination of amphetamines is hastened with a concomitant reduction in their duration of action.
- Urinary alkalinizers (e.g., sodium bicarb): Alkalinized urine may prolong the effects of amphetamines. Avoid agents that may alkalinize urine, particularly in overdose situations.
- Lithium carbonate: Inhibits anorectic and stimulatory effects of amphetamines.
- MAOIs: Coadministration contraindicated during or within 14 days following the administration of MAOI.
- Methenamine: Urinary excretion of amphetamines is increased, and efficacy is reduced by acidifying agents used in methenamine therapy.
- Phenothiazines: Pharmacologic effects of amphetamines and congeners may be diminished. Amphetamines may exacerbate psychotic symptoms. (chlorpromazine can be used to treat amphetamine poisoning)
- SSRIs: Increased sensitivity to effect of sympathomimetics and increased risk of serotonin syndrome may occur.
- Adrenergic blockers: Inhibited by amphetamines.
- Antihistamines: Amphetamines may counteract the sedative effects of antihistamines.
- Antihypertensive agents: Amphetamines may antagonize the hypotensive effects of antihypertensives.
- Ethosuximide: Amphetamines may delay intestinal absorption of ethosuximide.
- Guanethidine: Amphetamines may reverse the hypotensive effects of guanethidine. If there is a loss of BP control, stop the amphetamine or switch to alternative hypotensive therapy.
- Meperidine: Amphetamines may potentiate the analgesic effect of meperidine.
- Norepinephrine: Amphetamines enhance the adrenergic effect of norepinephrine.
- Phenobarbital and phenytoin: May delay intestinal absorption of phenobarbital and phenytoin producing a synergistic anticonvulsant action.
- Tricyclic antidepressants: Amphetamines may enhance the activity of tricyclic antidepressants. Cardiovascular effects may be potentiated.

Methylphenidate and Dexmethylphenidate

- Antacids/Acid suppressants: Because the modified release characteristics of Ritalin LA are pH dependent, the coadministration of antacids or acid suppressants could alter the release of methylphenidate.
- Carbamazepine: Methylphenidate plasma concentrations and pharmacologic effects may be decreased. Larger doses of dexmethylphenidate may be needed.
- MAOIs: Contraindicated during treatment and within 14 days following discontinuation of an MAOI.
- Valproic Acid: Pharmacologic activity of these agents may be additive or synergistic, increasing the risk of CNS toxicities, including unusual head, neck, mouth, or tongue

movements, grinding of the teeth, fidgeting of the hands, and agitation. Close clinical monitoring is warranted.

- Anticonvulsants: Levels may be increased resulting in increased pharmacologic and toxic effects of anticonvulsants.
- Antidepressants: Pharmacologic effects of SSRIs may be increased by dexmethylphenidate, resulting in development of serotonin syndrome. However, methylphenidate and SSRIs have been used concurrently in an attempt to enhance the antidepressant response to the SSRI. Use with caution.
- Antihypertensives: Coadministration may cause decreased efficacy of antihypertensives.
- Clonidine: Serious adverse events have been noted with concomitant use.
- Coumarin anticoagulants: Human pharmacologic studies have shown that dexmethylphenidate and methylphenidate may inhibit the metabolism of coumarin anticoagulants. It may be necessary to adjust the dosage or monitor coagulation times when starting or stopping therapy.
- Vasopressor agents: Because of possible adverse effects upon blood pressure, use cautiously with pressor agents.
- Halogenated anesthetics/dexmethylphenidate: Coadministration may cause a sudden increase in blood pressure during surgery.

Atomoxetine

- QT Prolongation: An additive effect of atomoxetine with other drugs that prolong the QT interval cannot be excluded.
- CYP2D6 inhibitors: Concomitant use may increase atomoxetine steady state plasma concentrations.
- The effects of albuterol on heart rate and blood pressure may be potentiated by atomoxetine.
- MAOIs: Coadministration is contraindicated.
- Pressor agents: Possible combined effects on blood pressure.
- CYP3A substrates: Coadministration resulted in a 15% increase in midazolam AUC.
- Lobenguane: Atomoxetine may reduce uptake and diagnostic efficacy of iobenguane. Discontinue atomoxetine prior to iobenguane administration.

Guanfacine ER

- CYP3A4/5 inhibitors (e.g., ketoconazole): Coadministration may increase rate and extent of guanfacine exposure.
- CYP3A4 inducers (e.g., rifampin): Coadministration may decrease rate and extent of guanfacine exposure.
- Alpha-2 adrenergic agonists: Additive hypotension may occur.
- Valproic acid: Coadministration may increase serum valproic acid concentrations.
- Antihypertensive drugs: Pharmacodynamic effects may be additive.
- CNS depressants: Pharmacodynamic effects may be additive.
- TCAs: The antihypertensive effect of guanfacine may be decreased.

Clonidine ER

- Sedating drugs: Clonidine may potentiate the CNS-depressive effects of alcohol, barbiturates, or other sedating drugs.
- Tricyclic antidepressants: May block antihypertensive effects of clonidine and potentially life-threatening elevations in blood pressure may occur.
- Beta-adrenergic blocking agents: Attenuation or reversal of antihypertensive effect and potentially life-threatening increases in blood pressure may occur. Because of a potential for additive effects, such as bradycardia and AV block, caution is warranted in patients receiving clonidine concomitantly with agents known to affect sinus node function or AV nodal conduction.

- Calcium channel blockers: Because of a potential for additive effects, such as bradycardia and AV block, caution is warranted in patients receiving clonidine concomitantly with agents known to affect sinus node function or AV nodal conduction.
- Digitalis: Because of a potential for additive effects, such as bradycardia and AV block, caution is warranted in patients receiving clonidine concomitantly with agents know to affect sinus node function or AV nodal conduction.
- Mirtazapine: The pharmacologic effects of clonidine may be decreased by mirtazapine.
- Prazosin: The antihypertensive effectiveness of clonidine may be decreased.
- Tizanidine: Possible additive hypotensive effects may occur when clonidine and tizanidine are coadministered.
- Cyclosporine: The pharmacologic and toxic effects of cyclosporine may be increased by clonidine.

VIII. Adverse Reactions

Adverse effects of stimulant medications are usually mild and of short duration. Most side effects, such as decreased appetite, headaches, stomachaches, insomnia, nervousness, and social withdrawal, can usually be managed by adjusting the dosage and/or timing of administration

<u>Amphetamines</u>

- Cardiovascular: Elevation of blood pressure, MI, palpitations, reflex decrease in heart rate, stroke, sudden death, tachycardia, arrhythmias (at larger doses). There have been isolated reports of cardiomyopathy associated with long-term amphetamine use.
- CNS: Affect lability, agitation, anxiety, changes in libido, depression, dizziness, dysphoria, dyskinesia, euphoria, feeling jittery, headache, insomnia, irritability, overstimulation, restlessness, seizure, somnolence, tremor, psychotic episodes at recommended doses (rare). CNS stimulants have exacerbated Tourette disorder and motor and phonic tics.
- GI: Abdominal pain, constipation, dry mouth, diarrhea, nausea, unpleasant taste, vomiting, other GI disturbances. Anorexia and weight loss may occur as undesirable effects when amphetamines are used other than for their anorectic effect.
- Hypersensitivity: Hypersensitivity reactions, including anaphylaxis and angioedema; urticaria. Serious skin rashes, including Stevens-Johnson syndrome and toxic epidermal necrolysis.
- Miscellaneous: Dyspnea, erectile dysfunction, hyperhidrosis, impotence, pyrexia, rash, suppression of growth in children with long term stimulant use.

<u>Methylphenidate and Dexmethylphenidate</u>

- Skin irritation. (transdermal)
- Cardiovascular: Angina, arrhythmia, blood pressure increased or decreased, cerebral arteritis and/or occlusion, palpitations, pulse increased or decreased tachycardia.
- CNS: Dizziness, drowsiness, dyskinesia, headache, rare reports of Tourette syndrome, toxic psychosis.
- GI: Abdominal pain, nausea.
- Hypersensitivity: Hypersensitivity reactions including arthralgia, erythema multiforme with histopathological findings of necrotizing vasculitis, exfoliative dermatitis, fever, skin rash, thrombocytopenic purpura, and urticaria.
- Metabolic/Nutritional: Anorexia, weight loss during prolonged therapy.

<u>Atomoxetine</u>

- Children and adolescents: The most commonly observed adverse reactions in patients treated with atomoxetine (incidence of 5% or more and at least twice the incidence in placebo-treated patients, for twice-daily or once-daily dosing) were abdominal pain, decreased appetite, fatigue, nausea, somnolence, and vomiting.
- Adults: The most commonly observed adverse reactions in patients treated with atomoxetine (incidence of 5% or more and at least twice the incidence in placebo-treated patients) were

constipation, decreased appetite, dry mouth, dysmenorrhea, erectile dysfunction, fatigue, hot flush, insomnia, nausea, and urinary hesitation and/or urinary retention and/or dysuria.

Guanfacine ER

- The most commonly reported adverse reactions (occurring in 2% or more of patients) that were considered drug-related and reported in a greater percentage of patients taking guanfacine ER compared with patients taking placebo include dizziness, fatigue, headache, irritability, lethargy, somnolence, abdominal pain, constipation, dry mouth, nausea, decreased appetite and hypotension.

Clonidine ER

- Common adverse reactions (≥5%) reported during the treatment period were constipation, dry mouth, ear pain, emotional disorder, fatigue, increased body temperature, insomnia, irritability, nasal congestion, nightmares, somnolence, throat pain, and upper respiratory tract infection.

IX. Conclusion

Medication treatment for ADHD has increased dramatically over the past 10 years with stimulants becoming the most prescribed psychotropic drug for children. Scientific evidence shows that stimulants are an effective treatment for ADHD, with medication resulting in better symptomatic relief than treatment with behavioral therapy alone. However, the evidence for comparative efficacy and adverse events of drugs for treating ADHD is severely lacking in measuring functional or long-term outcomes. More rigorous studies are needed to establish the comparative effectiveness of medications used to treat ADHD.

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SD Medicaid Medications Used to Treat ADHD Utilization			
01/01/12 - 12/31/12			
Label Name	**Rx Num**	**Total Reimb Amt**	**Avg Cost per Script**
ADDERALL 10 MG TABLET	1	$8.35	$8.35
ADDERALL 15 MG TABLET	2	$65.75	$32.88
ADDERALL 20 MG TABLET	9	$3,536.13	$392.90
ADDERALL XR 10 MG CAPSULE	99	$15,931.02	$160.92
ADDERALL XR 15 MG CAPSULE	59	$11,515.04	$195.17
ADDERALL XR 20 MG CAPSULE	236	$46,067.86	$195.20
ADDERALL XR 25 MG CAPSULE	109	$19,325.11	$177.29
ADDERALL XR 30 MG CAPSULE	140	$30,024.69	$214.46
ADDERALL XR 5 MG CAPSULE	21	$4,517.69	$215.13
AMPHETAMINE SALTS 10 MG TAB	1003	$50,311.16	$50.16
AMPHETAMINE SALTS 12.5 MG TB	5	$270.19	$54.04
AMPHETAMINE SALTS 15 MG TAB	158	$7,373.66	$46.67
AMPHETAMINE SALTS 20 MG TABLET	674	$46,346.31	$68.76
AMPHETAMINE SALTS 30 MG TAB	339	$18,327.72	$54.06
AMPHETAMINE SALTS 5 MG TAB	449	$20,389.00	$45.41
AMPHETAMINE SALTS 7.5 MG TAB	4	$153.58	$38.40
CONCERTA ER 18 MG TABLET	26	$3,979.21	$153.05
CONCERTA ER 27 MG TABLET	29	$5,148.87	$177.55
CONCERTA ER 36 MG TABLET	78	$20,109.17	$257.81
CONCERTA ER 54 MG TABLET	28	$7,080.96	$252.89
D-AMPHETAMINE ER 10 MG CAPSULE	226	$45,369.98	$200.75
D-AMPHETAMINE ER 15 MG CAPSULE	214	$37,490.09	$175.19
D-AMPHETAMINE ER 5 MG CAPSULE	65	$7,495.16	$115.31
DAYTRANA 10 MG/9 HR PATCH	112	$18,295.80	$163.36
DAYTRANA 15 MG/9 HR PATCH	89	$15,082.17	$169.46
DAYTRANA 20 MG/9 HOUR PATCH	109	$17,254.19	$158.30
DAYTRANA 30 MG/9 HOUR PATCH	91	$16,007.44	$175.91
DEXMETHYLPHENIDATE 10 MG TAB	214	$13,990.59	$65.38
DEXMETHYLPHENIDATE 2.5 MG TAB	27	$722.79	$26.77
DEXMETHYLPHENIDATE 5 MG TAB	399	$15,601.92	$39.10
DEXTROAMP-AMPHET ER 10 MG CAP	1473	$209,537.65	$142.25
DEXTROAMP-AMPHET ER 15 MG CAP	1025	$155,125.78	$151.34
DEXTROAMP-AMPHET ER 20 MG CAP	2983	$520,442.44	$174.47
DEXTROAMP-AMPHET ER 25 MG CAP	776	$114,525.52	$147.58
DEXTROAMP-AMPHET ER 30 MG CAP	2292	$346,884.64	$151.35
DEXTROAMP-AMPHET ER 5 MG CAP	390	$64,034.24	$164.19
DEXTROAMPHETAMINE 10 MG TAB	99	$2,405.55	$24.30
DEXTROAMPHETAMINE 5 MG TAB	57	$1,864.76	$32.72
FOCALIN 10 MG TABLET	11	$464.15	$42.20
FOCALIN 2.5 MG TABLET	2	$31.19	$15.60
FOCALIN 5 MG TABLET	20	$606.61	$30.33
FOCALIN XR 10 MG CAPSULE	1317	$238,829.83	$181.34
FOCALIN XR 15 MG CAPSULE	987	$173,158.97	$175.44

SD Medicaid Medications Used to Treat ADHD Utilization			
01/01/12 - 12/31/12			
Label Name	**Rx Num**	**Total Reimb Amt**	**Avg Cost per Script**
FOCALIN XR 20 MG CAPSULE	1063	$182,448.86	$171.64
FOCALIN XR 25 MG CAPSULE	69	$11,880.58	$172.18
FOCALIN XR 30 MG CAPSULE	525	$100,491.67	$191.41
FOCALIN XR 35 MG CAPSULE	2	$404.10	$202.05
FOCALIN XR 40 MG CAPSULE	131	$26,512.96	$202.39
FOCALIN XR 5 MG CAPSULE	586	$104,758.38	$178.77
INTUNIV ER 1 MG TABLET	1231	$215,554.94	$175.11
INTUNIV ER 2 MG TABLET	2760	$467,761.71	$169.48
INTUNIV ER 3 MG TABLET	1861	$311,481.43	$167.37
INTUNIV ER 4 MG TABLET	1400	$232,514.10	$166.08
KAPVAY ER 0.1 MG TABLET	96	$16,924.27	$176.29
METADATE CD 10 MG CAPSULE	115	$17,214.99	$149.70
METADATE CD 20 MG CAPSULE	284	$42,076.49	$148.16
METADATE CD 30 MG CAPSULE	148	$20,141.57	$136.09
METADATE CD 40 MG CAPSULE	127	$24,938.64	$196.37
METADATE CD 50 MG CAPSULE	30	$7,238.04	$241.27
METADATE CD 60 MG CAPSULE	5	$1,311.19	$262.24
METADATE ER 20 MG TABLET	11	$766.95	$69.72
TABLET	55	$20,278.89	$368.71
METHYLIN 10 MG TABLET	19	$181.36	$9.55
METHYLIN 10 MG/5 ML SOLUTION	9	$1,967.92	$218.66
METHYLIN 2.5 MG CHEWABLE TAB	21	$5,386.80	$256.51
METHYLIN 20 MG TABLET	5	$83.96	$16.79
METHYLIN 5 MG CHEWABLE TABLET	24	$5,475.61	$228.15
METHYLIN 5 MG TABLET	32	$322.61	$10.08
METHYLIN 5 MG/5 ML SOLUTION	3	$427.28	$142.43
METHYLIN ER 10 MG TABLET	26	$816.02	$31.39
METHYLIN ER 20 MG TABLET	11	$310.42	$28.22
METHYLPHENIDATE 10 MG TABLET	1274	$14,652.26	$11.50
METHYLPHENIDATE 10 MG/5 ML SOL	36	$6,758.18	$187.73
METHYLPHENIDATE 20 MG TABLET	473	$7,417.48	$15.68
METHYLPHENIDATE 5 MG TABLET	945	$9,697.74	$10.26
METHYLPHENIDATE 5 MG/5 ML SOLN	2	$218.13	$109.07
METHYLPHENIDATE ER 10 MG TAB	119	$2,859.65	$24.03
METHYLPHENIDATE ER 18 MG TAB	2491	$357,327.98	$143.45
METHYLPHENIDATE ER 20 MG CAP	152	$20,508.79	$134.93
METHYLPHENIDATE ER 20 MG TAB	212	$5,735.63	$27.05
METHYLPHENIDATE ER 27 MG TAB	2713	$416,815.47	$153.64
METHYLPHENIDATE ER 30 MG CAP	109	$14,633.20	$134.25
METHYLPHENIDATE ER 36 MG TAB	6020	$1,158,802.60	$192.49
METHYLPHENIDATE ER 40 MG CAP	78	$9,629.60	$123.46
METHYLPHENIDATE ER 54 MG TAB	4089	$685,965.96	$167.76
METHYLPHENIDATE SR 20 MG TAB	55	$2,445.84	$44.47

SD Medicaid Medications Used to Treat ADHD Utilization			
01/01/12 - 12/31/12			
Label Name	**Rx Num**	**Total Reimb Amt**	**Avg Cost per Script**
RITALIN 10 MG TABLET	1	$10.96	$10.96
RITALIN 20 MG TABLET	2	$15.62	$7.81
RITALIN 5 MG TABLET	1	$8.23	$8.23
RITALIN LA 10 MG CAPSULE	139	$22,577.57	$162.43
RITALIN LA 20 MG CAPSULE	91	$14,601.83	$160.46
RITALIN LA 30 MG CAPSULE	73	$11,911.71	$163.17
RITALIN LA 40 MG CAPSULE	43	$6,670.92	$155.14
STRATTERA 10 MG CAPSULE	196	$45,488.93	$232.09
STRATTERA 100 MG CAPSULE	186	$35,925.24	$193.15
STRATTERA 18 MG CAPSULE	322	$64,368.23	$199.90
STRATTERA 25 MG CAPSULE	924	$165,344.79	$178.94
STRATTERA 40 MG CAPSULE	1180	$213,213.82	$180.69
STRATTERA 60 MG CAPSULE	726	$135,509.13	$186.65
STRATTERA 80 MG CAPSULE	436	$86,961.32	$199.45
VYVANSE 20 MG CAPSULE	1371	$211,388.63	$154.19
VYVANSE 30 MG CAPSULE	2674	$410,750.07	$153.61
VYVANSE 40 MG CAPSULE	1974	$297,318.93	$150.62
VYVANSE 50 MG CAPSULE	1991	$298,309.79	$149.83
VYVANSE 60 MG CAPSULE	978	$148,533.63	$151.87
VYVANSE 70 MG CAPSULE	1600	$236,960.91	$148.10
Totals 6,896 recipients	**60772**	**$9,264,713.44**	

Prescribers (top 25)
15 Psychiatrists
7 Pediatricians
2 NP
1 PA
Top 25 prescribers make up ~ 42% of claims

Summary by Age		
Age	Recip Count	Rx Count
3	5	11
4	45	239
5	155	1082
6	276	2286
7	410	3701
8	513	4807
9	553	5323
10	562	5453
11	539	5283
12	511	4940
13	484	4735
14	449	3881
15	394	3563
16	356	3133
17	341	2715
18	282	2204
19	170	1050
20	66	514
21	50	483
22	52	411
23	48	370
24	47	398
25	26	200
26	30	197
27	31	216
28	30	208
29	24	188
30	32	206
31	31	198
32	34	205
33	23	115

Summary by Age		
Age	Recip Count	Rx Count
34	35	303
35	28	252
36	23	182
37	23	184
38	16	99
39	12	122
40	14	124
41	15	120
42	12	89
43	16	111
44	10	53
45	13	80
46	10	79
47	7	63
48	3	23
49	9	56
50	2	24
51	10	110
52	8	50
53	9	55
54	5	20
55	5	42
56	3	24
57	3	33
58	4	21
59	4	51
60	5	36
61	5	53
62	1	11
63	1	12
64	3	34

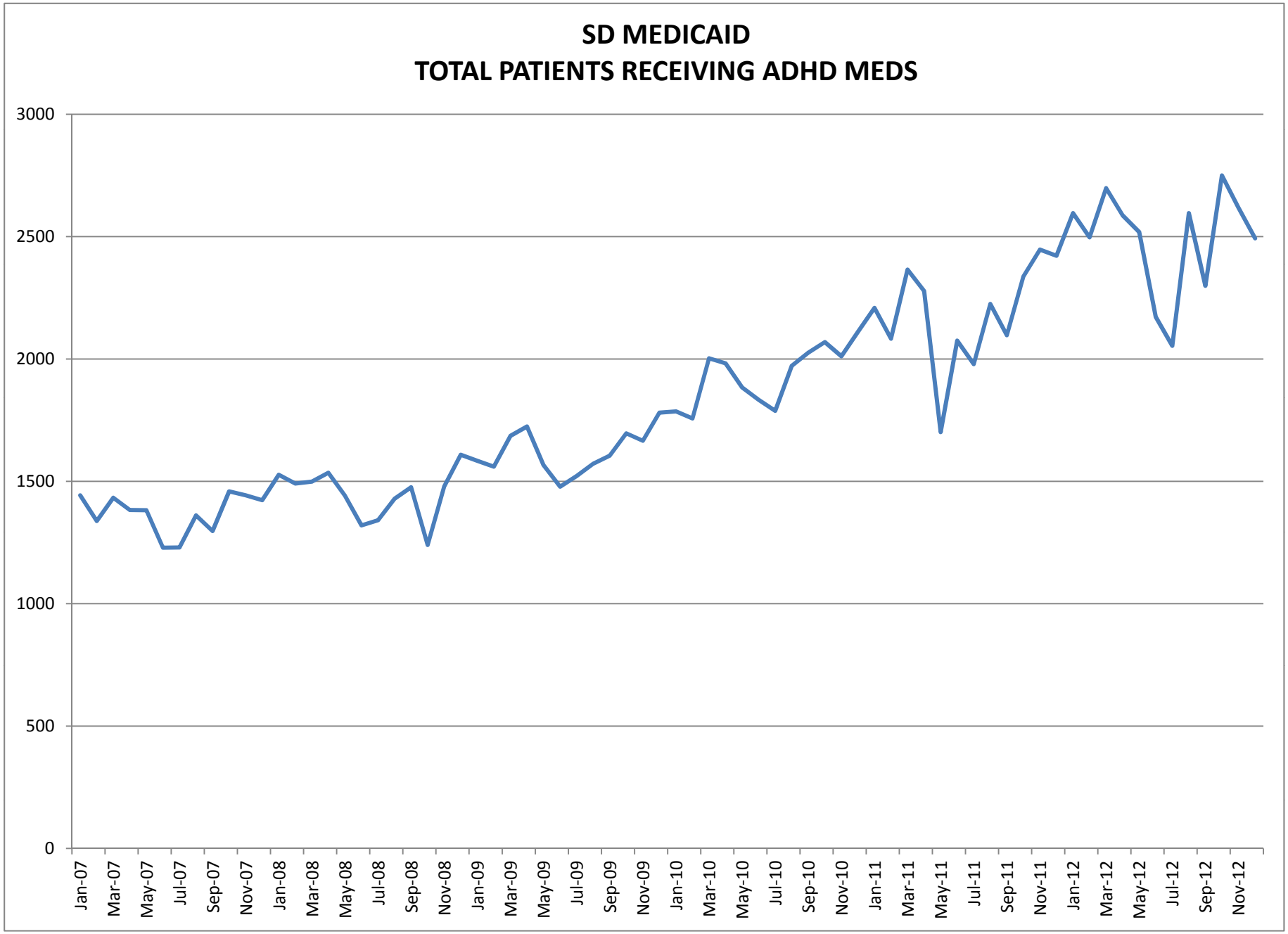
Age Distribution
3-5 2.2% of claims
6-10 35.49% of claims
11-15 36.86% of claims
16-20 15.82% of claims
21 and older 9.63% of claims
3-18 87.80% of claims

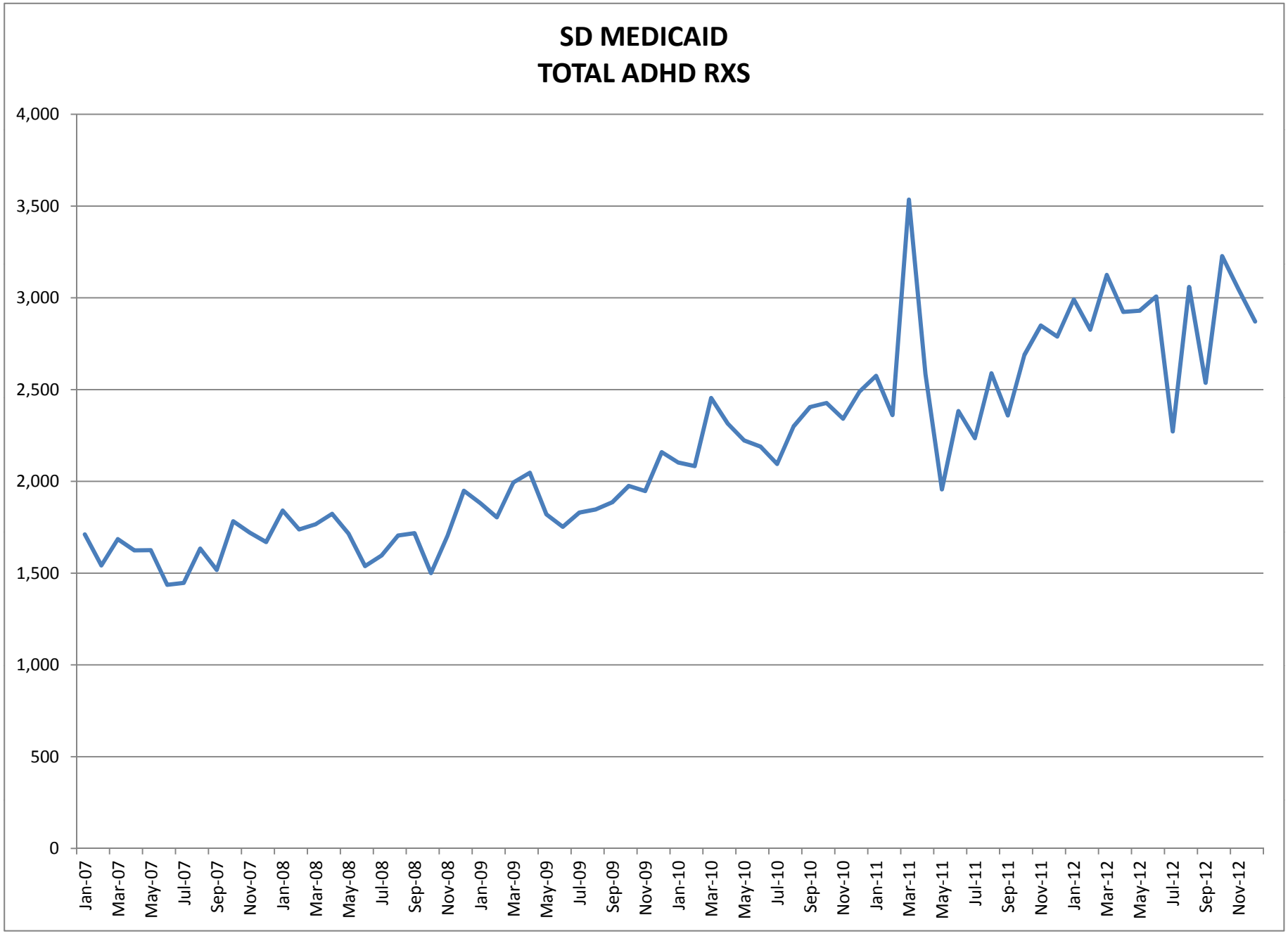
Consecutive Duplication for Medications Used to Treat ADHD	
01/01/2012 - 12/31/2012	
Overlap of 90 days	
Unique Recipients = 102, Unique Prescribers = 125	Occurences
CONCERTA , INTUNIV , METHYLPHENIDATE ER	6
DEXMETHYLPHENIDATE HCL , FOCALIN XR , INTUNIV	6
AMPHETAMINE SALT COMBO , INTUNIV , METHYLPHENIDATE HCL , STRATTERA , VYVANSE	5
DEXTROAMPHET-AMPHET , METHYLPHENIDATE ER , METHYLPHENIDATE HCL , RITALIN LA	5
METHYLPHENIDATE ER , METHYLPHENIDATE HCL , VYVANSE	5
INTUNIV , METHYLPHENIDATE ER , METHYLPHENIDATE HCL	5
INTUNIV , METHYLPHENIDATE ER , METHYLPHENIDATE HCL , VYVANSE	5
AMPHETAMINE COMBO , DEXMETHYLPHENIDATE HCL , FOCALIN XR , INTUNIV , VYVANSE	5
ADDERALL XR , DEXTROAMPHETAMINE-AMPHETAMINE , INTUNIV	5
INTUNIV , METHYLPHENIDATE ER , VYVANSE	5
INTUNIV , METHYLPHENIDATE HCL , VYVANSE	4
CONCERTA , METHYLPHENIDATE ER , METHYLPHENIDATE HCL	4
CONCERTA , INTUNIV , METHYLPHENIDATE ER , VYVANSE	4
DEXMETHYLPHENIDATE HCL , METHYLPHENIDATE ER , METHYLPHENIDATE HCL	4
DEXMETHYLPHENIDATE HCL , FOCALIN XR , INTUNIV	4
AMPHETAMINE SALT COMBO , DEXTROAMPHETAMINE-AMPHETAMINE , INTUNIV , STRATTER	4
DAYTRANA , INTUNIV , VYVANSE	4
METHYLPHENIDATE ER , METHYLPHENIDATE HCL , STRATTERA	4
AMPHETAMINE SALT COMBO , DEXTROAMPHETAMINE-AMPHETAMINE , INTUNIV , VYVANSE	4
DEXMETHYLPHENIDATE HCL , FOCALIN , FOCALIN XR	4
DEXMETHYLPHENIDATE HCL , FOCALIN XR , INTUNIV	4
INTUNIV , METHYLPHENIDATE ER , METHYLPHENIDATE HCL	4
INTUNIV , METHYLPHENIDATE ER , METHYLPHENIDATE HCL	4
DEXMETHYLPHENIDATE HCL , FOCALIN XR , INTUNIV	3
FOCALIN XR , INTUNIV , METHYLPHENIDATE ER , STRATTERA , VYVANSE	3
DAYTRANA , FOCALIN XR , METADATE CD , STRATTERA	3
AMPHETAMINE SALT COMBO , DEXTROAMPHETAMINE-AMPHETAMINE , INTUNIV	3
INTUNIV , METHYLPHENIDATE HCL , VYVANSE	3
INTUNIV , METHYLPHENIDATE ER , STRATTERA	3
INTUNIV , METHYLPHENIDATE ER , METHYLPHENIDATE HCL	3
AMPHETAMINE COMBO , INTUNIV , METHYLPHENIDATE ER , METHYLPHEN HCL , VYVANSE	3
FOCALIN XR , METHYLPHENIDATE HCL , STRATTERA	3
AMPHETAMINE SALT COMBO , DEXTROAMPHETAMINE-AMPHETAMINE , INTUNIV , KAPVAY	3
DEXTROAMPHETAMINE-AMPHETAMINE , INTUNIV , STRATTERA , VYVANSE	3
INTUNIV , METHYLPHENIDATE ER , METHYLPHENIDATE HCL	3
INTUNIV , METHYLPHENIDATE ER , VYVANSE	3
DEXMETHYLPHENIDATE HCL , FOCALIN XR , INTUNIV	3
DEXMETHYLPHENIDATE HCL , FOCALIN , FOCALIN XR , INTUNIV	3
DEXTROAMPHETAMINE-AMPHETAMINE , INTUNIV , VYVANSE	3
INTUNIV , METHYLPHENIDATE ER , VYVANSE	3
ADDERALL XR , DEXTROAMPHETAMINE-AMPHETAMINE , STRATTERA	3
ADDERALL XR , AMPHETAMINE SALT COMBO , DEXTROAMPHET-AMPHET , INTUNIV	3
INTUNIV , METHYLPHENIDATE ER , METHYLPHENIDATE HCL , STRATTERA	3
INTUNIV , STRATTERA , VYVANSE	3
DAYTRANA , DEXMETHYLPHEN HCL , FOCALIN XR , INTUNIV , METHYLPHEN ER , METHYLPHI	3
INTUNIV , METHYLPHENIDATE ER , METHYLPHENIDATE HCL , VYVANSE	3
INTUNIV , METHYLPHENIDATE ER , METHYLPHENIDATE HCL	3
AMPHETAMINE SALT COMBO , INTUNIV , METHYLPHENIDATE ER , VYVANSE	3
AMPHETAMINE SALT COMBO , FOCALIN XR , VYVANSE	2

Consecutive Duplication for Medications Used to Treat ADHD	
01/01/2012 - 12/31/2012	
Overlap of 90 days	
Unique Recipients = 102, Unique Prescribers = 125	Occurences
ADDERALL XR , DEXTROAMPHETAMINE-AMPHETAMINE , INTUNIV	2
DEXMETHYLPHENIDATE HCL , FOCALIN XR , STRATTERA	2
AMPHETAMINE SALT COMBO , INTUNIV , VYVANSE	2
AMPHETAMINE SALT COMBO , INTUNIV , STRATTERA , VYVANSE	2
INTUNIV , METHYLPHENIDATE ER , METHYLPHENIDATE HCL	2
ADDERALL XR , DEXTROAMPHETAMINE-AMPHETAMINE , INTUNIV	2
DEXMETHYLPHENIDATE HCL , FOCALIN XR , INTUNIV , VYVANSE	2
INTUNIV , METADATE CD , METHYLPHENIDATE ER , METHYLPHENIDATE HCL	2
DEXMETHYLPHENIDATE HCL , INTUNIV , STRATTERA	2
DEXMETHYLPHENIDATE HCL , FOCALIN XR , INTUNIV	2
DEXTROAMPHETAMINE SULFATE , INTUNIV , VYVANSE	2
DEXTROAMPHETAMINE-AMPHETAMINE , FOCALIN XR , INTUNIV , METHYLPHENIDATE ER	2
DEXTROAMPHETAMINE-AMPHETAMINE , INTUNIV , METHYLPHENIDATE ER	2
DEXMETHYLPHENIDATE HCL , FOCALIN XR , INTUNIV	2
DEXTROAMPHET-AMPHET , INTUNIV , KAPVAY , METHYLPHEN ER , METHYLPHEN HCL , VYVA	2
DAYTRANA , DEXMETHYLPHENIDATE HCL , FOCALIN XR , INTUNIV	2
DEXMETHYLPHENIDATE HCL , FOCALIN XR , INTUNIV	2
FOCALIN XR , INTUNIV , METHYLPHENIDATE ER	2
AMPHETAMINE SALT COMBO , INTUNIV , VYVANSE	2
INTUNIV , METHYLPHENIDATE ER , STRATTERA	2
AMPHETAMINE SALT COMBO , INTUNIV , VYVANSE	2
AMPHETAMINE SALT COMBO , FOCALIN XR , INTUNIV , STRATTERA , VYVANSE	2
METHYLPHENIDATE ER , METHYLPHENIDATE HCL , STRATTERA	2
INTUNIV , METHYLPHENIDATE ER , METHYLPHENIDATE HCL	2
DEXTROAMPHETAMINE-AMPHETAMINE , INTUNIV , METHYLPHENIDATE ER	2
DEXMETHYLPHENIDATE HCL , FOCALIN , FOCALIN XR	2
DEXTROAMPHETAMINE-AMPHETAMINE , INTUNIV , STRATTERA	2
INTUNIV , METHYLPHENIDATE ER , METHYLPHENIDATE HCL	1
INTUNIV , STRATTERA , VYVANSE	1
ADDERALL XR , AMPHETAMINE SALT COMBO , DEXTROAMPHETAMINE-AMPHETAMINE	1
DEXMETHYLPHENIDATE HCL , FOCALIN , FOCALIN XR	1
DEXTROAMPHETAMINE-AMPHETAMINE , METHYLIN , METHYLPHENIDATE HCL	1
AMPHETAMINE SALT COMBO , FOCALIN XR , INTUNIV	1
DEXMETHYLPHENIDATE HCL , FOCALIN , FOCALIN XR	1
DEXMETHYLPHENIDATE HCL , FOCALIN XR , INTUNIV	1
ADDERALL XR , AMPHETAMINE SALT COMBO , DEXTROAMPHETAMINE-AMPHETAMINE	1
INTUNIV , METHYLPHENIDATE ER , STRATTERA	1
INTUNIV , METHYLPHENIDATE ER , VYVANSE	1
ADDERALL XR , AMPHETAMINE SALT COMBO , DEXTROAMPHET-AMPHET, INTUNIV	1
DEXTROAMPHETAMINE-AMPHETAMINE , METHYLPHENIDATE ER , STRATTERA	1
INTUNIV , METHYLIN , METHYLPHENIDATE ER	1
METHYLPHENIDATE ER , METHYLPHENIDATE HCL , STRATTERA	1
INTUNIV , METHYLPHENIDATE ER , VYVANSE	1
AMPHET COMBO , DEXTROAMPHET-AMPHET , METHYLPHEN ER , METHYLPHEN HCL , VYVAN	1
INTUNIV , METHYLPHENIDATE ER , METHYLPHENIDATE HCL	1
AMPHETAMINE SALT COMBO , METHYLPHENIDATE HCL , VYVANSE	1
AMPHETAMINE SALT COMBO , DEXTROAMPHETAMINE-AMPHETAMINE , INTUNIV	1
DEXTROAMPHETAMINE-AMPHETAMINE , INTUNIV , METHYLPHENIDATE ER	1
DEXMETHYLPHENIDATE HCL , INTUNIV , METHYLPHENIDATE HCL , VYVANSE	1

Consecutive Duplication for Medications Used to Treat ADHD	
01/01/2012 - 12/31/2012	
Overlap of 90 days	
Unique Recipients = 102, Unique Prescribers = 125	Occurences
INTUNIV , METHYLPHENIDATE ER , METHYLPHENIDATE HCL	1
INTUNIV , METADATE CD , METHYLIN , METHYLPHENIDATE HCL	1
DEXMETHYLPHENIDATE HCL , FOCALIN XR , INTUNIV	1
INTUNIV , METHYLPHENIDATE ER , VYVANSE	1

ADHD Consecutive Duplication Recipients		
Summary By Age		
Age	**Recip Count**	**Rx Count**
5	3	82
6	3	78
7	9	216
8	11	248
9	15	396
10	12	307
11	11	309
12	9	228
13	9	223
14	3	89
15	6	179
16	5	132
17	1	36
18	3	58
25	1	19
59	1	29


SD MEDICAID
TOTAL PATIENTS RECEIVING ADHD MEDS
3000
2500
2000
1500
1000
500
0
Jan-07
Mar-07
May-07
Jul-07
Sep-07
Nov-07
Jan-08
Mar-08
May-08
Jul-08
Sep-08
Nov-08
Jan-09
Mar-09
May-09
Jul-09
Sep-09
Nov-09
Jan-10
Mar-10
May-10
Jul-10
Sep-10
Nov-10
Jan-11
Mar-11
May-11
Jul-11
Sep-11
Nov-11
Jan-12
Mar-12
May-12
Jul-12
Sep-12
Nov-12


SD MEDICAID
TOTAL ADHD RXS
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
Jan-07
Mar-07
May-07
Jul-07
Sep-07
Nov-07
Jan-08
Mar-08
May-08
Jul-08
Sep-08
Nov-08
Jan-09
Mar-09
May-09
Jul-09
Sep-09
Nov-09
Jan-10
Mar-10
May-10
Jul-10
Sep-10
Nov-10
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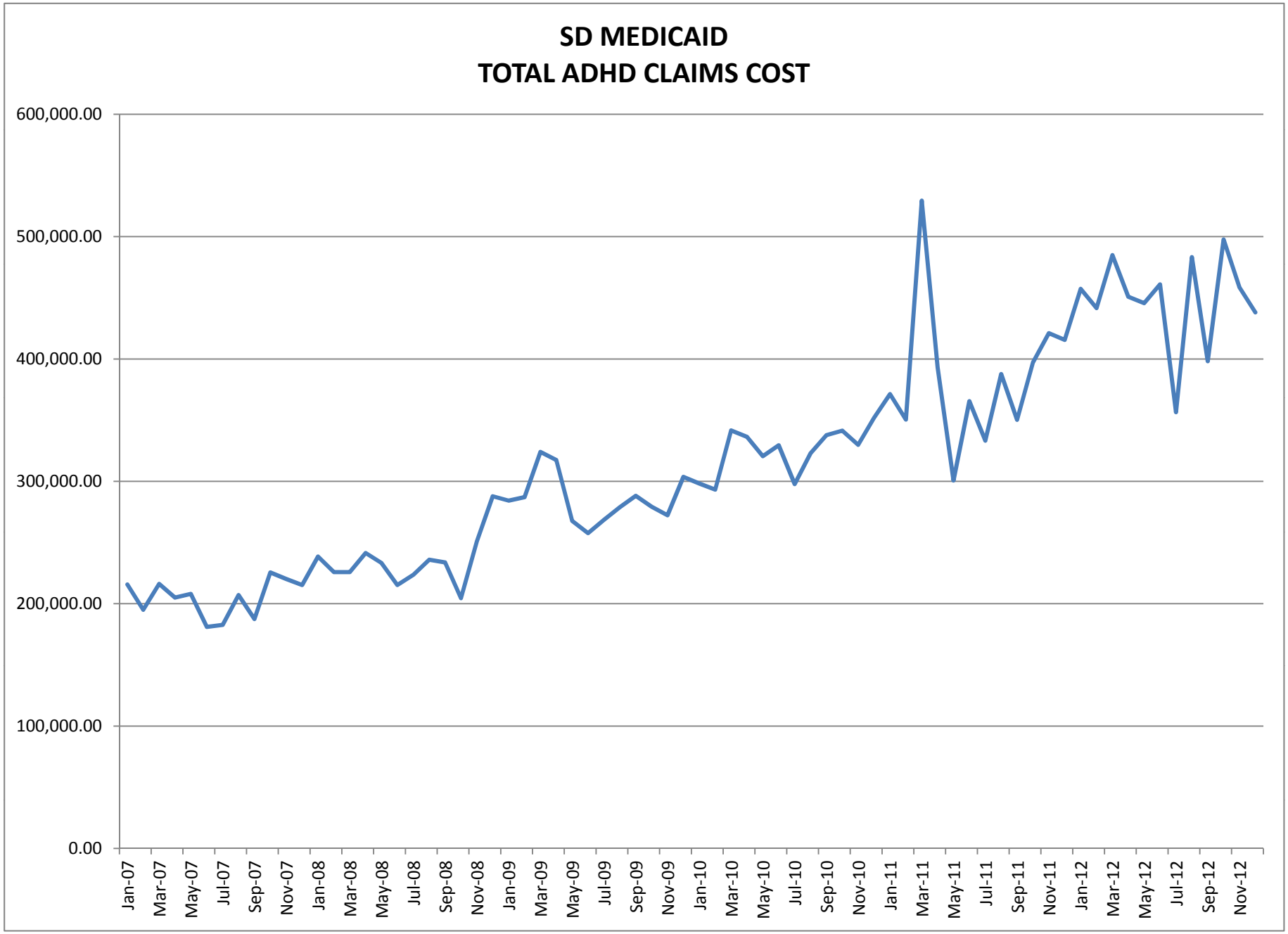
Jan-12
Mar-12
May-12
Jul-12
Sep-12
Nov-12


SD MEDICAID
TOTAL ADHD CLAIMS COST
600,000.00
500,000.00
400,000.00
300,000.00
200,000.00
100,000.00
0.00
Jan-07
Mar-07
May-07
Jul-07
Sep-07
Nov-07
Jan-08
Mar-08
May-08
Jul-08
Sep-08
Nov-08
Jan-09
Mar-09
May-09
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Mar-10
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Jul-10
Sep-10
Nov-10
Jan-11
Mar-11
May-11
Jul-11
Sep-11
Nov-11
Jan-12
Mar-12
May-12
Jul-12
Sep-12
Nov-12

SD Medicaid Opiate Agonist Utilization (AHFS 280808)			
01/01/12 - 12/31/12			
Label Name	**Rx Num**	**Total Reimb Amt**	**Avg Cost per Script**
ACETAMINOPH-CAFF-DIHYDROCODEIN	8	$452.40	$56.55
ACETAMINOPHEN/COD ELIXIR	4	$36.47	$9.12
ACETAMINOPHEN-COD #2 TABLET	11	$84.82	$7.71
ACETAMINOPHEN-COD #3 TABLET	3299	$30,429.70	$9.22
ACETAMINOPHEN-COD #4 TABLET	27	$540.75	$20.03
ACETAMINOPHEN-CODEINE SOLUTION	1413	$10,238.30	$7.25
ASCOMP WITH CODEINE CAPSULE	41	$1,329.32	$32.42
BELLADONNA-OPIUM 16.2-30 SUPP	2	$218.17	$109.09
BUTALB-CAFF-ACETAMINOPH-CODEIN	63	$1,124.66	$17.85
BUTALBITAL COMP-CODEINE #3 CAP	39	$1,308.72	$33.56
CAPITAL WITH CODEINE SUSP	3	$353.32	$117.77
CODEINE SULFATE 15 MG TABLET	1	$7.48	$7.48
CODEINE SULFATE 30 MG TABLET	2	$17.40	$8.70
DURAGESIC 25 MCG/HR PATCH	5	$689.39	$137.88
ENDOCET 10-325 MG TABLET	252	$12,358.96	$49.04
ENDOCET 10-650 MG TABLET	26	$1,110.10	$42.70
ENDOCET 5-325 TABLET	29	$174.30	$6.01
ENDOCET 7.5-325 MG TABLET	78	$3,416.03	$43.80
ENDOCET 7.5-500 MG TABLET	2	$97.16	$48.58
ENDODAN 4.83-325 MG TABLET	6	$206.00	$34.33
EXALGO ER 16 MG TABLET	2	$1,178.15	$589.08
EXALGO ER 8 MG TABLET	24	$10,256.20	$427.34
FENTANYL 100 MCG/HR PATCH	266	$63,567.26	$238.97
FENTANYL 12 MCG/HR PATCH	155	$12,586.82	$81.21
FENTANYL 25 MCG/HR PATCH	360	$20,542.83	$57.06
FENTANYL 50 MCG/HR PATCH	485	$58,628.88	$120.88
FENTANYL 75 MCG/HR PATCH	267	$41,131.61	$154.05
HYDROCODON-ACETAMINOPH 2.5-500	11	$137.73	$12.52
HYDROCODON-ACETAMINOPH 7.5-300	1	$52.72	$52.72
HYDROCODON-ACETAMINOPH 7.5-325	1074	$23,583.55	$21.96
HYDROCODON-ACETAMINOPH 7.5-500	779	$6,826.63	$8.76
HYDROCODON-ACETAMINOPH 7.5-650	4	$31.72	$7.93
HYDROCODON-ACETAMINOPH 7.5-750	141	$1,063.48	$7.54
HYDROCODON-ACETAMINOPHEN 5-300	7	$366.10	$52.30
HYDROCODON-ACETAMINOPHEN 5-325	11691	$154,663.62	$13.23
HYDROCODON-ACETAMINOPHEN 5-500	6423	$39,355.24	$6.13
HYDROCODON-ACETAMINOPHN 10-325	4169	$80,776.57	$19.38
HYDROCODON-ACETAMINOPHN 10-500	796	$11,833.43	$14.87
HYDROCODON-ACETAMINOPHN 10-650	703	$6,945.10	$9.88
HYDROCODON-ACETAMINOPHN 10-660	12	$145.20	$12.10
HYDROCODON-ACETAMINOPHN 10-750	10	$566.60	$56.66
HYDROCODONE-ACETAMINOPHEN SOLN	1477	$13,890.95	$9.40
HYDROCODONE-IBUPROFEN 7.5-200	546	$6,643.59	$12.17

SD Medicaid Opiate Agonist Utilization (AHFS 280808)			
01/01/12 - 12/31/12			
Label Name	**Rx Num**	**Total Reimb Amt**	**Avg Cost per Script**
HYDROMORPHONE 1 MG/ML SOLUTION	1	$14.32	$14.32
HYDROMORPHONE 2 MG TABLET	217	$3,009.38	$13.87
HYDROMORPHONE 3 MG SUPPOS	4	$1,218.36	$304.59
HYDROMORPHONE 4 MG TABLET	183	$3,732.98	$20.40
HYDROMORPHONE 8 MG TABLET	35	$2,825.78	$80.74
KADIAN ER 10 MG CAPSULE	2	$562.02	$281.01
KADIAN ER 30 MG CAPSULE	1	$310.68	$310.68
KADIAN ER 50 MG CAPSULE	3	$1,115.45	$371.82
KADIAN ER 80 MG CAPSULE	1	$405.21	$405.21
LORTAB 5-500 TABLET	1	$4.30	$4.30
MEPERIDINE 50 MG TABLET	78	$1,249.67	$16.02
MEPERITAB 100 MG TABLET	1	$52.00	$52.00
METHADONE 10 MG/5 ML SOLUTION	2	$30.39	$15.20
METHADONE 5 MG/5 ML SOLUTION	24	$169.10	$7.05
METHADONE HCL 10 MG TABLET	444	$9,010.21	$20.29
METHADONE HCL 5 MG TABLET	36	$314.54	$8.74
MORPHINE 10 MG/ML SYRINGE	7	$88.89	$12.70
MORPHINE 10 MG/ML VIAL	3	$49.03	$16.34
MORPHINE 2 MG/ML SYRINGE	2	$37.24	$18.62
MORPHINE 300 MG/20 ML VIAL	1	$12.46	$12.46
MORPHINE SULF 10 MG/5 ML SOLN	52	$421.80	$8.11
MORPHINE SULF 100 MG/5 ML SOLN	22	$434.96	$19.77
MORPHINE SULF 20 MG/5 ML SOLN	1	$4.67	$4.67
MORPHINE SULF ER 100 MG TABLET	48	$2,665.77	$55.54
MORPHINE SULF ER 15 MG TABLET	329	$6,780.55	$20.61
MORPHINE SULF ER 200 MG TABLET	12	$2,226.00	$185.50
MORPHINE SULF ER 30 MG TABLET	470	$15,372.82	$32.71
MORPHINE SULF ER 60 MG TABLET	172	$6,412.94	$37.28
MORPHINE SULFATE ER 100 MG CAP	6	$4,912.00	$818.67
MORPHINE SULFATE ER 30 MG CAP	3	$706.27	$235.42
MORPHINE SULFATE ER 60 MG CAP	1	$42.30	$42.30
MORPHINE SULFATE ER 80 MG CAP	8	$4,585.31	$573.16
MORPHINE SULFATE IR 15 MG TAB	418	$4,115.18	$9.84
MORPHINE SULFATE IR 30 MG TAB	129	$2,786.27	$21.60
NUCYNTA 100 MG TABLET	43	$15,390.85	$357.93
NUCYNTA 50 MG TABLET	98	$14,039.50	$143.26
NUCYNTA 75 MG TABLET	44	$10,127.29	$230.17
NUCYNTA ER 100 MG TABLET	19	$5,142.64	$270.67
NUCYNTA ER 150 MG TABLET	13	$4,664.66	$358.82
NUCYNTA ER 200 MG TABLET	11	$5,206.56	$473.32
NUCYNTA ER 50 MG TABLET	8	$1,169.61	$146.20
OPANA 5 MG TABLET	3	$1,120.06	$373.35
OPANA ER 10 MG TABLET	53	$10,965.34	$206.89

SD Medicaid Opiate Agonist Utilization (AHFS 280808)			
01/01/12 - 12/31/12			
Label Name	**Rx Num**	**Total Reimb Amt**	**Avg Cost per Script**
OPANA ER 20 MG TABLET	70	$25,738.55	$367.69
OPANA ER 30 MG TABLET	33	$19,448.89	$589.36
OPANA ER 40 MG TABLET	28	$27,667.21	$988.11
OPANA ER 5 MG TABLET	16	$1,840.30	$115.02
OPANA ER 7.5 MG TABLET	3	$411.36	$137.12
OXYCODON-ACETAMINOPHEN 2.5-325	3	$105.03	$35.01
OXYCODON-ACETAMINOPHEN 7.5-325	138	$4,293.67	$31.11
OXYCODON-ACETAMINOPHEN 7.5-500	8	$113.17	$14.15
OXYCODONE CONC 20 MG/ML SOLN	4	$590.10	$147.53
OXYCODONE HCL 10 MG TABLET	269	$7,083.36	$26.33
OXYCODONE HCL 15 MG TABLET	426	$16,503.84	$38.74
OXYCODONE HCL 20 MG TABLET	34	$2,238.07	$65.83
OXYCODONE HCL 30 MG TABLET	73	$2,705.12	$37.06
OXYCODONE HCL 5 MG CAPSULE	116	$2,356.59	$20.32
OXYCODONE HCL 5 MG TABLET	1919	$33,991.16	$17.71
OXYCODONE HCL 5 MG/5 ML SOL	44	$704.59	$16.01
OXYCODONE HCL CR 20 MG TABLET	3	$451.06	$150.35
OXYCODONE HCL CR 80 MG TABLET	4	$1,826.83	$456.71
OXYCODONE-ACETAMINOPHEN 10-325	604	$24,402.98	$40.40
OXYCODONE-ACETAMINOPHEN 10-650	33	$1,202.42	$36.44
OXYCODONE-ACETAMINOPHEN 5-325	4411	$28,088.77	$6.37
OXYCODONE-ACETAMINOPHEN 5-500	182	$986.78	$5.42
OXYCODONE-ASA 4.5-0.38-325 TAB	2	$64.60	$32.30
OXYCODONE-ASPIRIN 4.83-325 MG	7	$358.87	$51.27
OXYCONTIN 10 MG TABLET	351	$34,642.13	$98.70
OXYCONTIN 15 MG TABLET	59	$9,050.31	$153.40
OXYCONTIN 20 MG TABLET	540	$133,307.26	$246.87
OXYCONTIN 30 MG TABLET	189	$64,027.68	$338.77
OXYCONTIN 40 MG TABLET	454	$168,093.38	$370.25
OXYCONTIN 60 MG TABLET	131	$67,113.83	$512.32
OXYCONTIN 80 MG TABLET	136	$128,609.22	$945.66
OXYMORPHONE HCL 10 MG TABLET	11	$6,125.20	$556.84
OXYMORPHONE HCL 5 MG TABLET	18	$5,626.69	$312.59
OXYMORPHONE HCL ER 7.5 MG TAB	6	$499.75	$83.29
PERCOCET 2.5-325 MG TABLET	1	$78.15	$78.15
PERCOCET 5-325 MG TABLET	1	$2.31	$2.31
ROXICET 5-325 ORAL SOLUTION	25	$660.74	$26.43
ROXICET 5-325 TABLET	4	$21.33	$5.33
RYBIX ODT 50 MG TABLET	1	$102.00	$102.00
RYZOLT ER 300 MG TABLET	7	$1,974.42	$282.06
TRAMADOL ER 100 MG TABLET	1	$59.46	$59.46
TRAMADOL ER 200 MG TABLET	1	$60.11	$60.11
TRAMADOL ER 300 MG TABLET	13	$3,243.03	$249.46

SD Medicaid Opiate Agonist Utilization (AHFS 280808)			
01/01/12 - 12/31/12			
Label Name	**Rx Num**	**Total Reimb Amt**	**Avg Cost per Script**
TRAMADOL HCL 50 MG TABLET	11671	$97,689.63	$8.37
TRAMADOL HCL ER 100 MG TABLET	43	$3,693.92	$85.91
TRAMADOL HCL ER 200 MG TABLET	101	$15,992.80	$158.34
TRAMADOL HCL ER 300 MG TABLET	67	$14,141.76	$211.07
TRAMADOL-ACETAMINOPHN 37.5-325	279	$6,506.12	$23.32
ULTRAM 50 MG TABLET	3	$34.17	$11.39
ULTRAM ER 200 MG TABLET	11	$2,096.62	$190.60
ULTRAM ER 300 MG TABLET	16	$5,151.02	$321.94
VICODIN 5-500 TABLET	1	$2.05	$2.05
ZAMICET SOLUTION	53	$3,064.41	$57.82
Totals 14,919 recipients	**60,347**	**$1,737,315.61**	**2,730 prescribers**

Prescriber Specialties (top 25)
14 Family Practice
3 NP/PA
2 Pain Management
2 Oral Surgery
1 OBGYN
1 Internist
1 ENT
1 Emergency Medicine
Top 25 prescribers make up ~ 18% of claims

78 recipients had 3 or more opiates filled using 3 or more prescribers in a 30 day period of time
12/01/12 - 12/31/12
1 recipient - 6 prescribers
2 recipients - 5 prescribers
11 recipients - 4 prescribers
64 recipients - 3 prescribers
30 recipients had 3 or more opiates filled using 3 or more pharmacies in a 30 day period of time
12/01/12 - 12/31/12
29 recipients - 3 pharmacies
1 recipient - 4 pharmacies

Summary by Age

Age	Recip Count	Rx Count
6	123	152
7	136	177
8	125	146
9	133	161
10	127	158
11	130	171
12	153	220
13	165	251
14	225	332
15	251	367
16	309	592
17	454	818
18	499	951
19	439	762
20	226	447
21	262	566
22	277	696
23	277	743
24	325	1026
25	313	866
26	346	1275
27	278	1005
28	262	967
29	277	1143
30	249	1059
31	227	991
32	220	1057
33	195	967
34	165	938
35	169	806
36	157	967
37	152	1015
38	132	801
39	112	831
40	122	779
41	118	787
42	115	751
43	106	795

Summary by Age

Age	Recip	Rx Count
44	97	929
45	85	639
46	77	846
47	78	578
48	91	763
49	112	1109
50	88	880
51	94	815
52	99	981
53	89	977
54	71	594
55	83	755
56	78	692
57	78	765
58	74	747
59	67	434
60	65	585
61	57	482
62	46	419
63	42	512
64	39	377
65	33	250
66	1	1
67	2	6
69	2	8
73	1	6
80	1	3

Narcotic Utilization Summary by County			
County	**Recip Count**	**Rx Count**	**Total Dollars**
Minnehaha	2060	9947	$305,780.48
Pennington	1749	6352	$222,695.98
Todd	448	2236	$51,331.55
Shannon	374	1022	$19,500.32
Brown	358	1857	$47,402.23
Yankton	324	1483	$80,539.45
Codington	291	846	$12,317.12
Davison	261	905	$19,061.32
Dewey	253	810	$16,863.16
Meade	247	998	$37,564.04
Hughes	238	972	$24,201.63
Lawrence	231	972	$32,239.36
Butte	183	567	$18,934.28
Corson	175	930	$12,729.73
Brookings	169	689	$25,683.51
Charles Mix	163	633	$39,139.29
Bennett	158	597	$6,016.50
Lincoln	148	480	$12,453.00
Beadle	144	636	$22,844.15
Roberts	127	468	$9,062.39
Clay	120	529	$12,538.12
Jackson	103	215	$2,442.43
Union	88	276	$7,549.48
Tripp	86	418	$8,977.51
Ziebach	78	223	$2,091.54
Turner	77	399	$5,979.41
Gregory	75	306	$5,467.94
Walworth	74	590	$24,866.10
Spink	73	358	$5,854.71
Fall River	72	418	$15,415.45
Lyman	61	379	$12,192.66
Bon Homme	55	215	$4,374.39
Day	54	230	$5,998.77
Lake	54	254	$13,471.19
Day	52	239	$8,829.63
Mellette	52	240	$3,620.70
Moody	49	227	$6,141.64
Brule	48	246	$5,512.80
Grant	48	262	$10,906.12
Hamlin	47	132	$1,620.48
Hutchinson	42	292	$17,577.69
McCook	40	186	$6,011.79
Buffalo	39	135	$2,213.02

Narcotic Utilization Summary by County			
County	**Recip Count**	**Rx Count**	**Total Dollars**
Deuel	34	94	$4,453.06
Stanley	31	91	$1,542.64
Kingsbury	25	59	$944.16
Douglas	23	97	$2,461.13
Marshall	23	154	$7,172.61
Sanborn	22	92	$1,166.18
Aurora	20	38	$325.88
Clark	18	145	$1,926.25
Miner	18	111	$6,103.50
Edmunds	16	33	$309.36
Hand	16	73	$3,045.35
Jones	15	55	$6,876.59
Hanson	14	55	$557.37
McPherson	14	51	$639.31
Faulk	11	39	$2,344.80
Haakon	11	65	$1,210.67
Jerauld	11	50	$603.58
Perkins	10	41	$611.64
Potter	10	59	$1,745.29
Sully	9	10	$86.21
Harding	8	10	$152.58
Campbell	4	15	$163.61
Hyde	2	19	$228.43

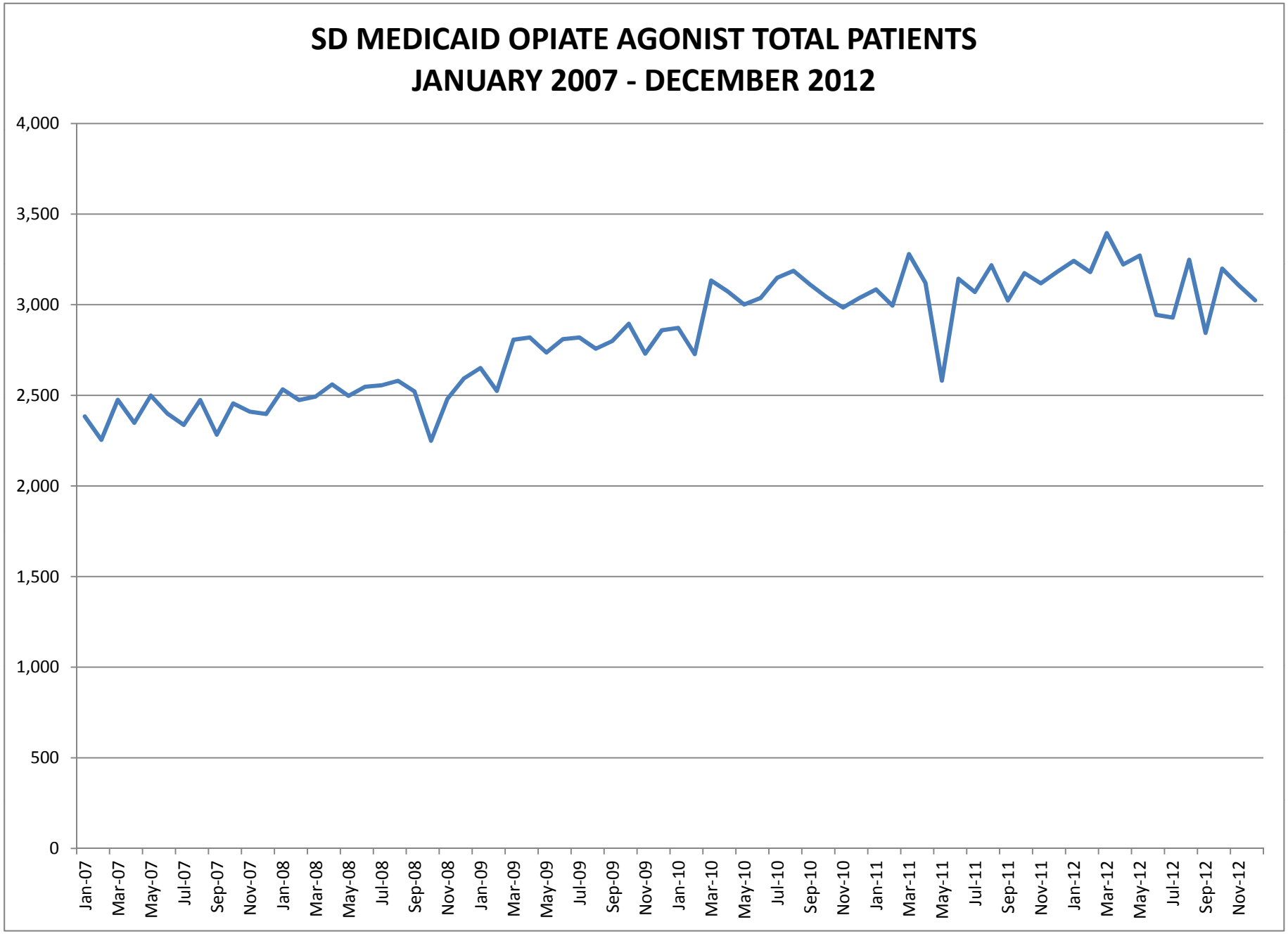
Top 100 Recipients by Script Count of Opiate Agonists	
01/01/12 - 12/31/12	
Recipient #	**Number of Scripts**
1	111
2	93
3	86
4	81
5	75
6	75
7	74
8	71
9	67
10	67
11	65
12	63
13	62
14	62
15	61
16	58
17	57
18	56
19	56
20	56
21	56
22	55
23	55
24	55
25	55
26	54
27	54
28	54
29	54
30	53
31	53
32	53
33	53
34	52
35	52
36	52
37	51
38	51
39	51
40	51
41	51
42	50
43	50
44	50
45	49
46	49
47	49
48	49
49	48
50	47

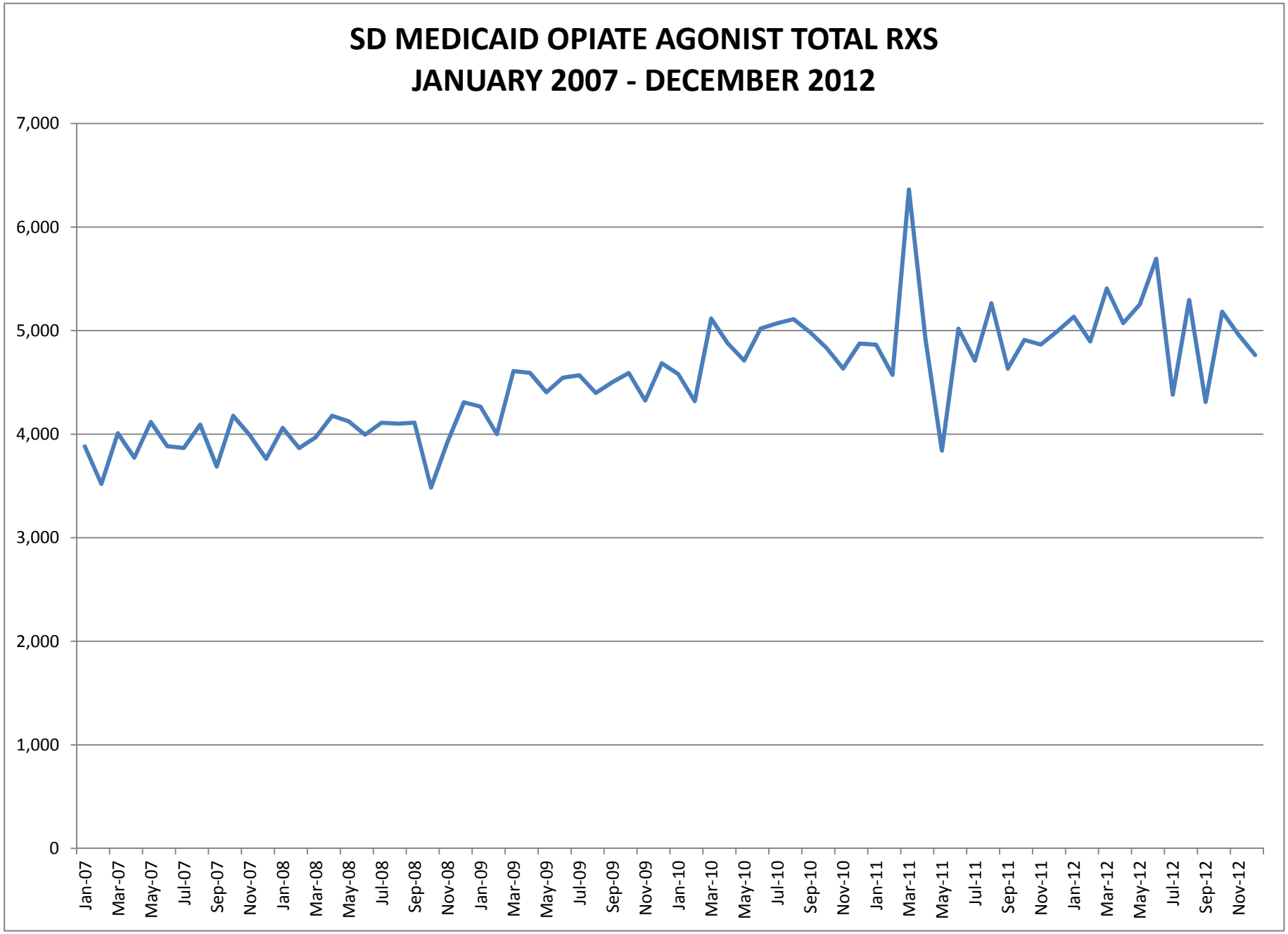
Top 100 Recipients by Script Count of Opiate Agonists	
01/01/12 - 12/31/12	
Recipient #	**Number of Scripts**
51	47
52	47
53	46
54	45
55	45
56	44
57	44
58	44
59	43
60	42
61	42
62	42
63	42
64	42
65	42
66	42
67	41
68	41
69	41
70	41
71	41
72	41
73	40
74	40
75	40
76	40
77	40
78	40
79	40
80	40
81	39
82	39
83	39
84	39
85	39
86	39
87	39
88	39
89	39
90	38
91	38
92	38
93	38
94	38
95	38
96	38
97	38
98	38
99	38
100	38

Top 100 Prescribers by Script Count of Opiate Agonists	
01/01/12 - 12/31/12	
Prescriber #	**Number of Scripts**
1	1459
2	954
3	639
4	586
5	572
6	513
7	502
8	418
9	397
10	345
11	344
12	338
13	332
14	326
15	320
16	316
17	293
18	271
19	266
20	264
21	264
22	258
23	252
24	247
25	238
26	236
27	216
28	215
29	213
30	212
31	211
32	209
33	206
34	206
35	203
36	201
37	201
38	199
39	196
40	196
41	192
42	191
43	185
44	180
45	180
46	179
47	174
48	173
49	169
50	168

Top 100 Prescribers by Script Count of Opiate Agonists	
01/01/12 - 12/31/12	
Prescriber #	**Number of Scripts**
51	168
52	167
53	166
54	165
55	163
56	159
57	157
58	156
59	154
60	153
61	149
62	149
63	148
64	147
65	146
66	146
67	145
68	145
69	145
70	144
71	141
72	141
73	140
74	139
75	139
76	138
77	136
78	136
79	136
80	135
81	135
82	134
83	129
84	128
85	128
86	127
87	126
88	125
89	124
90	124
91	123
92	123
93	123
94	123
95	121
96	119
97	119
98	117
99	117
100	117

Top Diagnoses of Recipients Taking Opiate Agonists		
01/01/2012-12/31/2012		
DX Code	**DX Description**	**Count**
V221	SUPERVISION OTHER NORMAL PREGNANCY	13,710
78900	ABDOMINAL PAIN UNS SITE	13,340
7242	LUMBAGO	12,604
25000	DIABETES UNCOMPL TYPE II	10,083
7999	OTH UNKNOWN/UNS MORBIDITY/MORTALITY	8,757
4019	UNSPECIFIED ESSENTIAL HYPERTENSION	8,531
311	DEPRESSIVE DISORDER OTHER	7,975
7840	HEADACHE	7,020
462	ACUTE PHARYNGITIS	6,870
71946	PAIN IN JOINT LOWER LEG	6,601
7295	PAIN IN LIMB	6,436
78650	UNSPEC CHEST PAIN	5,821
3671	MYOPIA	5,814
7862	COUGH	5,544
7245	BACKACHE UNSPECIFIED	5,399
V5869	ENCOUNTER LONG TERM USE OTH DRUGS	5,386
5990	URINARY TRACT INFECTION UNSPEC	5,358
7231	CERVICALGIA	5,220
78079	OTHER MALAISE AND FATIGUE	5,159
71941	PAIN IN JOINT SHOULDER	4,876


SD MEDICAID OPIATE AGONIST TOTAL PATIENTS
JANUARY 2007 - DECEMBER 2012
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
Jan-07
Mar-07
May-07
Jul-07
Sep-07
Nov-07
Jan-08
Mar-08
May-08
Jul-08
Sep-08
Nov-08
Jan-09
Mar-09
May-09
Jul-09
Sep-09
Nov-09
Jan-10
Mar-10
May-10
Jul-10
Sep-10
Nov-10
Jan-11
Mar-11
May-11
Jul-11
Sep-11
Nov-11
Jan-12
Mar-12
May-12
Jul-12
Sep-12
Nov-12


SD MEDICAID OPIATE AGONIST TOTAL RXS
JANUARY 2007 - DECEMBER 2012
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
Jan-07
Mar-07
May-07
Jul-07
Sep-07
Nov-07
Jan-08
Mar-08
May-08
Jul-08
Sep-08
Nov-08
Jan-09
Mar-09
May-09
Jul-09
Sep-09
Nov-09
Jan-10
Mar-10
May-10
Jul-10
Sep-10
Nov-10
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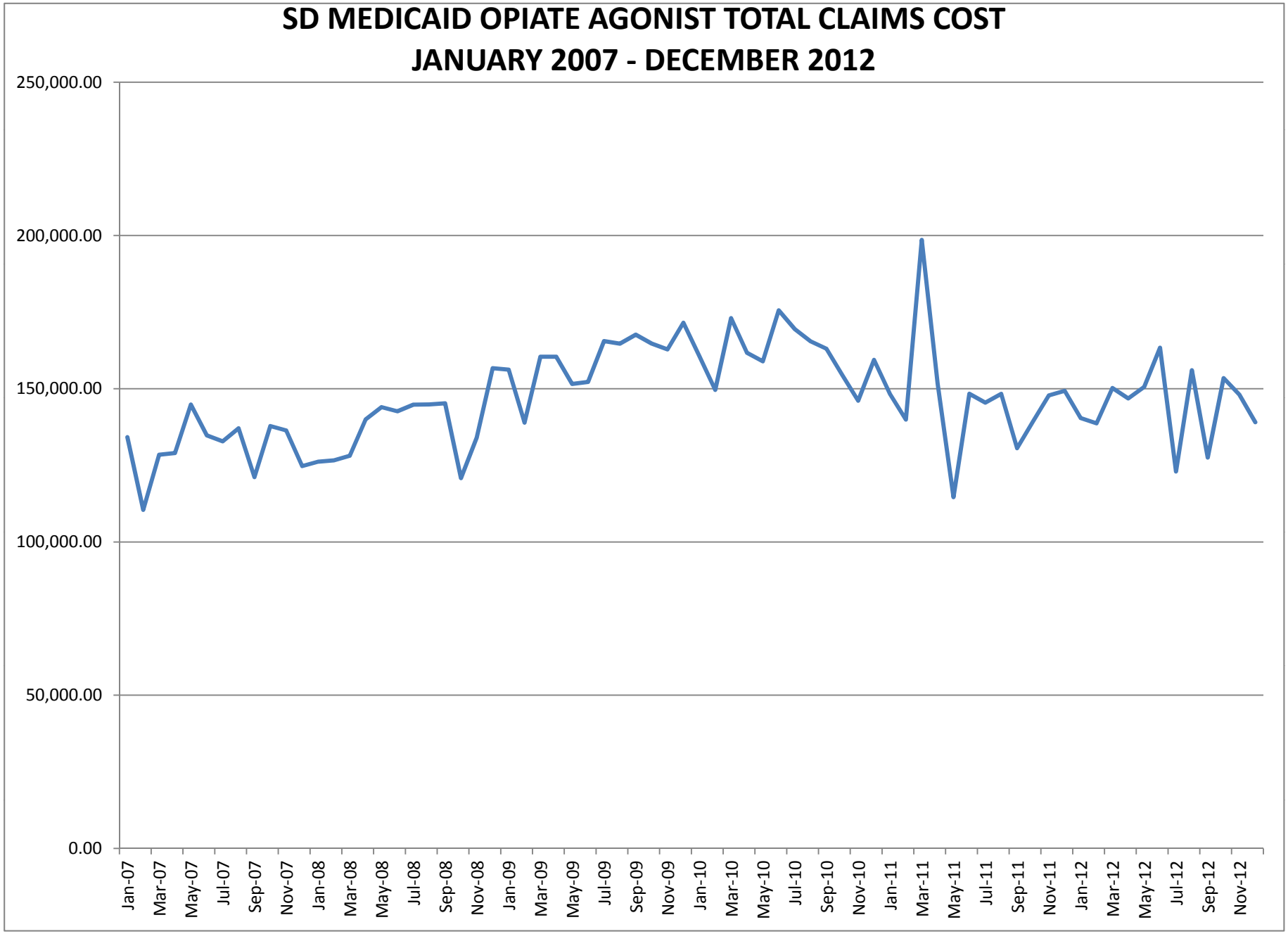
Jan-12
Mar-12
May-12
Jul-12
Sep-12
Nov-12


SD MEDICAID OPIATE AGONIST TOTAL CLAIMS COST
JANUARY 2007 - DECEMBER 2012
250,000.00
200,000.00
150,000.00
100,000.00
50,000.00
0.00
Jan-07
Mar-07
May-07
Jul-07
Sep-07
Nov-07
Jan-08
Mar-08
May-08
Jul-08
Sep-08
Nov-08
Jan-09
Mar-09
May-09
Jul-09
Sep-09
Nov-09
Jan-10
Mar-10
May-10
Jul-10
Sep-10
Nov-10
Jan-11
Mar-11
May-11
Jul-11
Sep-11
Nov-11
Jan-12
Mar-12
May-12
Jul-12
Sep-12
Nov-12

South Dakota Department of Social Services
Pharmacotherapy Review
Juxtapid®

I. Indication

Juxtapid (lomitapide) is a microsomal triglyceride transfer protein inhibitor indicated as an adjunct to a low-fat diet and other lipid-lowering treatments, including LDL apheresis where available, to reduce low-density lipoprotein cholesterol (LDL-C), total cholesterol (TC), apolipoprotein B (apo B), and non-high-density lipoprotein cholesterol (non-HDL-C) in patients with homozygous familial hypercholesterolemia (HoFH).

II. Dosage and Administration

- Before treatment, measure ALT, AST, alkaline phosphatase, and total bilirubin; obtain a negative pregnancy test in females of reproductive potential; and initiate a low-fat diet supplying <20% of energy from fat.
- Initiate treatment at 5mg once daily. Titrate dose based on acceptable safety/tolerability: increase to 10mg daily after at least 2 weeks; and then, at a minimum of 4-week intervals, to 20mg, 40mg, and up to the maximum recommended dose of 60mg daily.
- Due to reduced absorption of fat-soluble vitamins/fatty acids: Take daily vitamin E, linoleic acid, alpha-linolenic acid (ALA), eicosapentaenoic acid (EPA), and docosahexaenoic acid (DHA) supplements.
- Take once daily, whole, with water and without food, at least 2 hours after evening meal.
- Patients with end-stage renal disease on dialysis or with baseline mild hepatic impairment should not exceed 40mg daily.

III. Contraindications

- Pregnancy.
- Concomitant use with strong or moderate CYP3A4 inhibitors.
- Moderate or severe hepatic impairment or active liver disease including unexplained persistent abnormal liver function tests.

IV. Warnings and Precautions

- Black Box Warning: Risk of hepatotoxicity.
- Embryo-Fetal Toxicity: Females of reproductive potential should have a negative pregnancy test before starting and use contraception during treatment.
- Gastrointestinal adverse reactions occur in 93% of patients and could affect absorption of concomitant oral medications.

V. Adverse Reactions

The most common adverse reactions (incidence ≥28%) are diarrhea, nausea, vomiting, dyspepsia, and abdominal pain.

VI. Drug Interactions

- CYP3A4 inhibitors increase exposure to lomitapide. Strong and moderate CYP3A4 inhibitors are contraindicated. Patients must avoid grapefruit juice. Do not exceed 30 mg daily when used concomitantly with weak CYP3A4 inhibitors, including atorvastatin and oral contraceptives.
- Warfarin: Lomitapide increases plasma concentrations of warfarin. Monitor international normalized ratio (INR) regularly, especially with dose adjustment.
- Simvastatin and lovastatin exposure increase. Limit dose when co-administered due to myopathy risk.
- P-glycoprotein (P-gp) Substrates: Consider dose reduction of P-gp substrate because of possible increased absorption.
- Bile Acid Sequestrants: Separate Juxtapid dosing by at least 4 hours.

Reference

1. Juxtapid® [prescribing information]. Cambridge, MA. Aegerion Pharmaceuticals, Inc.; Dec 2012.

South Dakota Department of Social Services
Pharmacotherapy Review
Gattex®

I. Indication

Gattex (teduglutide [rDNA origin]) for injection is a glucagon-like peptide-2 (GLP-2) analog indicated for the treatment of adult patients with Short Bowel Syndrome (SBS) who are dependent on parenteral support.

II. Dosage and Administration

- The recommended once daily dose is 0.05mg/kg.
- Administer by subcutaneous injection; alternate sites between 1 of the 4 quadrants of the abdomen, or into alternating thighs or alternating arms.
- 50% dosage reduction recommended in patients with moderate to severe renal impairment.
- For single-use only. Use within 3 hours after reconstitution, discard any unused portion.

III. Warnings and Precautions

- Neoplastic Growth – There is a risk for acceleration of neoplastic growth. Colonoscopy of the entire colon with removal of polyps should be done before initiating treatment and is recommended after 1 year. Subsequent colonoscopies should be done as needed, but no less frequently than every 5 years. In case of intestinal malignancy, discontinue. The clinical decision to continue in patients with non-gastrointestinal malignancy should be made based on risk and benefit considerations.
- Intestinal obstruction – In patients who develop obstruction, Gattex should be temporarily discontinued pending further clinical evaluation and management.
- Biliary and pancreatic disease – Patients should undergo lab assessment before starting. Subsequent lab tests should be done every 6 months.
- Fluid overload – There is a potential for fluid overload while on Gattex. If fluid overload occurs, especially in patients with cardiovascular disease, parenteral support should be appropriately adjusted, and Gattex treatment reassessed.

IV. Adverse Reactions

The most common adverse reactions (incidence ≥10%) across all studies with Gattex are abdominal pain, injection site reactions, nausea, headaches, abdominal distension, upper respiratory tract infection. In addition, vomiting and fluid overload were reported in the SBS studies.

V. Drug Interactions

Gattex has the potential to increase absorption of concomitant oral medications. Careful monitoring and possible dose adjustment of oral medications that require titration or have a narrow therapeutic index is recommended.

Reference

1. Gattex® [prescribing information]. McPherson, KS. Hospira, Inc.; Dec 2012.