South Dakota
Department of Social Services

Medicaid P&T Committee Meeting

March 16, 2018

DSS

Strong Families - South Dakota's Foundation and Our Future

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Strong Families - South Dakota's Foundation and Our Future

SOUTH DAKOTA
MEDICAID P&T COMMITTEE MEETING
AGENDA

March 16, 2018
1:00 – 3:00 PM

DDN Locations:
Sioux Falls
University Center
DDN Room FADM145
4801 North Career Avenue

Pierre
Capitol Building
DDN Room CAP A
500 East Capitol

Rapid City
Black Hills State University
DDN Room UC113
4300 Cheyenne Boulevard

Call to order

Approval of minutes of previous meeting

PA update

Review of top 15 therapeutic categories/top 50 drugs

Old business
- **Peer-to-peer update**
- **Review of Duzallo & Zurampic**
- **Review PA forms & criteria**
- **Pipeline & patent expiration**

New business
- **FDA Advisory Committee recommendations – opioid cough suppressants in children**
- **Review of Ingrezza**
- **Review of Xepi**

Oral presentations and comments by manufacturers' representatives

Next meeting date/adjournment

South Dakota Department of Social Services, Division of Medicaid Services
Pharmacy & Therapeutics (P&T) Committee Meeting Minutes

Friday, December 1, 2017
1:00 – 3:00 pm CT

Members and DSS Staff

Michelle Baack, MD		Kelley Oehlke, PharmD	X
Dana Darger, RPh		Lenny Petrik, PharmD	X
James Engelbrecht, MD	X	Timothy Soundy, MD	
Mikal Holland, MD	X	Mike Jockheck, DSS Staff	X
Richard Holm, MD	X	Sarah Akers, DSS Staff	X
Bill Ladwig, RPh, Chair	X	Bill Snyder, DSS Staff	X

Administrative Business

The meeting was called to order by Ladwig at 1:04 PM. The minutes of the September meeting were presented. Holm made a motion to approve. Oehlke seconded the motion. Motion was approved unanimously.

Prior Authorization Update (PA) and Statistics

The committee reviewed the PA activity report for October 2017. There were a total of 2,954 PAs processed in the month of October, with 99.97% of those requests responded to in less than eight hours. There were 2265 requests (77%) received electronically and 689 requests (23%) received via fax.

Analysis of the Top 15 Therapeutic Classes and Drug Spend

The committee reviewed the top 15 therapeutic classes by total cost of claims from 7/1/2017 to 9/30/2017. The top five classes were antipsychotic agents, insulins, respiratory and CNS stimulants, amphetamines, and anticonvulsants. The top 15 therapeutic classes make up 26.70% of total claims. The committee also reviewed the top 50 drugs based on total claims cost and number of claims. The top 50 drugs by claims cost make up 10.93% of total claims. Antidepressants dropped from the top 15 therapeutic classes by total cost of claims this quarter. Holland inquired about the total quarterly spend; Ladwig inquired about the total annual spend.

Treatment Options for Opioid Abuse

Tiffany Wolfgang from the Division of Behavioral Health, Department of Social Services provided an overview of *South Dakota's State Targeted Response to the Opioid Crisis* project and *Opioid Misuse in South Dakota Summary–2017 Needs Assessment Findings*. *South Dakota's State Targeted Response to the Opioid Crisis* project assesses the impact of the opioid epidemic in South Dakota and provide coordinated efforts in the areas of education, prevention, treatment and recovery. The project time period is from May 2017 to April 2019. Wolfgang also reviewed South Dakota's Substance Use Disorder Services which provides services throughout communities within the state. The agency location in each area can found at the following websites:

SAMHSA Treatment Locator – https://findtreatment.samhsa.gov
DSS – http://dss.sd.gov/behavioralhealth/agencycounty.aspx

In addition, Wolfgang highlighted South Dakota Community Mental Health Centers available to both adults and youth. There are 11 community centers available throughout the state. Services include screenings and assessments, case management, individual therapy, group therapy, and crisis

intervention. Individuals who qualify may be eligible for state funded services. Wolfgang also stressed the importance of education and training of naloxone, safe use and disposal of opioids, increase use of PDMP, and prevention/education as key strategies.

Opioid Utilization and Strategies for Management & Opioid Naïve Limit
Committee reviewed the opioid utilization summary of recipients utilizing greater than 300 MED. Holland recommended sending letters to the top prescribers to notify them of all the treatment centers available in the South Dakota community; and to remind providers of prescribing over the acceptable standard. Engelbrecht broached the concept of peer-to-peer reviews. He indicated that private insurance invests a great deal of time providing peer-to-peer communication. The peer-to-peer would open discussions and intercept these high utilization. The committee strongly recommended peer-to-peer calls. Other discussion ensued on the topics of lock-in, opioid naïve limits, decreasing high utilizers down to a lower MED limit, tightening the early refill threshold from 75% to 85%, and limiting the number of short and long acting opioids for recipients.

There are approximately 120,000 Medicaid recipients, of which roughly 100 recipients have high utilization. Although this is not at the national epidemic level, South Dakota Medicaid wants to proactively manage opioid utilization. Committee recommended capping the MED at 300. Utilization over 300 MED would require PA; diagnosis of terminal illness would be exempt. The MED would be decreased by 50 MED intervals and a new PA limit is set at the new lowered limit until the goal of 100 MED is reached. Then PA would be required for recipients receiving over 100 MED. This would provide prescribers and their patients time to formulate a taper schedule. Advance provider notifications to be communicated mid to early 2018.

Ladwig motioned to change the refill threshold from 75% to 85%. Holm seconded the motion. The motion was approved unanimously.

Committee also discussed initiating limits for opioids naïve patients as those patients without an opioid prescription in the past 60 days. Ladwig stressed that a 7 day supply is sufficient. System capabilities to be determined.

Holm inquired about limiting recipients to one long and one short acting opioids; anything over this limit would require PA. For example, multiple strengths of Fentanyl would be allowed, but not Fentanyl and Oxycontin dispensed together. System capabilities to be determined before implementing this PA.

The P&T committee recommended the following opioid utilization initiatives:

1. Peer-to-peer communications
2. MED monitoring for utilizers over 300 MED and subsequent tapering schedule
3. Initiate opioid naïve limit – identified as no opioids in the 60 days; allow 7 day supply and 60 MED limit
4. PA on utilization with more than one long acting and one shorting acting opioids
5. Tighten opioid refill threshold from 75% to 85% (add 3 days)

State will present to the committee on the initiatives the State is able to accomplish. Committee also requested an opioid report at subsequent meeting. Oehlke recommended supplying a standard checklist and resources available for peers (naloxone availability, urine drug screening, checking PDMP, resources, compassionate care, etc). Holm made a motion for the State to move towards these initiatives. Oehlke seconded the motion. The motion was approved unanimously.

Duzallo Review
Duzallo clinical information was presented for review. The committee recommended a PA on both Duzallo and Zurampic; with a trial of allopurinol first. Both drugs will be brought back to the next meeting for further review. Cost and utilization information were requested.

Xhance Review
Xhance clinical information was presented for review. The committee recommended adding Xhance to the nasal steroid step therapy. Holm motioned adding Xhance to PA using generics first. Oehlke seconded the motion. The motion was approved unanimously.

Next meeting is scheduled for 3/16/2018. Meeting dates of 6/8/2018 and 9/7/2018 were also scheduled. Holm made a motion to adjourn. Oehlke seconded. The meeting adjourned at 2:22 PM.

PA Update 4Q2017

Compliance Summary

Priority	Total PAs	PAs Compliant Standard - 72 Hrs Urgent - 24 Hrs	PAs Not Compliant	% PAs Compliant	% PAs Not Compliant
STANDARD	733	733	0	100.00%	0.00%
URGENT	43	43	0	100.00%	0.00%

Drug Class Summary

Drug Class	Approved	Denied	Partially Favorable
COMPOUND	0	1	0
5-HT3 RECEPTOR ANTAGONISTS	63	44	0
ALPHA-ADRENERGIC BLOCKING AGENTS	1	0	0
AMINOGLYCOSIDES	5	0	0
AMPHETAMINES	4	6	0
ANGIOTENSIN II RECEPTOR ANTAGONISTS	1	1	0
ANTIALLERGIC AGENTS	5	8	0
ANTIBACTERIALS (SKIN, MUCOUS MEMBRANE)	4	2	1
ANTICONVULSANTS, MISCELLANEOUS	31	34	0
ANTIDEPRESSANTS, MISCELLANEOUS	2	7	0
ANTIGOUT AGENTS	1	1	0
ANTIHISTAMINES (GI DRUGS)	12	3	0
ANTIMUSCARINICS	4	7	0
ANTINEOPLASTIC AGENTS	4	1	0
ANTIPRURITICS AND LOCAL ANESTHETICS	0	18	0
ANXIOLYTICS,SEDATIVES,AND HYPNOTICS,MISC	5	5	0
ATYPICAL ANTIPSYCHOTICS	73	21	1
AZOLES (SKIN AND MUCOUS MEMBRANE)	1	0	0
BENZODIAZEPINES (ANTICONVULSANTS)	9	0	0
BENZODIAZEPINES (ANXIOLYTIC,SEDATIV/HYP)	0	1	0
BETA-ADRENERGIC BLOCKING AGENTS	1	1	0
BIGUANIDES	1	0	0
CALCIUM-CHANNEL BLOCKING AGENTS, MISC.	0	1	0
CELL STIMULANTS AND PROLIFERANTS	1	1	0
CENTRAL ALPHA-AGONISTS	2	1	0
CENTRAL NERVOUS SYSTEM AGENTS, MISC.	4	2	0
CENTRALLY ACTING SKELETAL MUSCLE RELAXNT	4	1	0
CONTRACEPTIVES	1	0	0
CORTICOSTEROIDS (EENT)	0	1	0
DIHYDROPYRIDINES	1	0	0
DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS	0	1	0
DIRECT FACTOR XA INHIBITORS	5	0	0
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	25	4	0
ERGOT-DERIV. DOPAMINE RECEPTOR AGONISTS	0	1	0
GI DRUGS, MISCELLANEOUS	6	1	0
HCV POLYMERASE INHIBITORS	2	2	0

HCV PROTEASE INHIBITORS	4	0	0
HEPARINS	9	2	0
HISTAMINE H2-ANTAGONISTS	0	1	0
IMMUNOMODULATORY AGENTS	3	2	0
IMMUNOSUPPRESSIVE AGENTS	2	0	0
INCRETIN MIMETICS	3	0	0
INSULINS	3	0	0
LEUKOTRIENE MODIFIERS	2	0	0
NITRATES AND NITRITES	1	0	0
OPIATE AGONISTS	25	8	0
OPIATE PARTIAL AGONISTS	20	2	0
OTHER MISCELLANEOUS THERAPEUTIC AGENTS	1	0	0
OTHER NONSTEROIDAL ANTI-INFLAM. AGENTS	1	1	0
PCSK9 INHIBITORS	1	2	0
PHOSPHODIESTERASE TYPE 5 INHIBITORS	1	0	0
PROGESTINS	0	1	0
PROTECTIVE AGENTS	0	1	0
PROTON-PUMP INHIBITORS	27	14	1
REPLACEMENT PREPARATIONS	3	0	0
RESPIRATORY AND CNS STIMULANTS	17	11	0
RESPIRATORY TRACT AGENTS, MISCELLANEOUS	4	1	0
RIFAMYCINS	3	0	0
SCABICIDES AND PEDICULICIDES	23	3	0
SECOND GENERATION ANTIHISTAMINES	13	2	0
SEL.SEROTONIN,NOREPI REUPTAKE INHIBITOR	23	8	0
SELECTIVE BETA-2-ADRENERGIC AGONISTS	0	1	0
SELECTIVE BETA-3-ADRENERGIC AGONISTS	1	0	0
SELECTIVE SEROTONIN AGONISTS	2	8	0
SELECTIVE-SEROTONIN REUPTAKE INHIBITORS	14	1	0
SEROTONIN MODULATORS	1	0	0
SKIN AND MUCOUS MEMBRANE AGENTS, MISC.	14	2	0
SOMATOTROPIN AGONISTS	4	3	0
VASODILATING AGENTS (RESPIRATORY TRACT)	2	0	0
VESICULAR MONOAMINE TRANSPORT2 INHIBITOR	2	2	0
VITAMIN D	0	1	0
VITAMIN K ACTIVITY	1	1	0
WAKEFULNESS-PROMOTING AGENTS	7	3	0
TOTAL	**515**	**258**	**3**

Request Type Summary

Drug Class	# of Requests	Phone Requests #	Phone Requests %	Fax Requests #	Fax Requests %
ANTIBACTERIALS (SKIN, MUCOUS MEMBRANE)	7	2	28.57%	5	71.43%
VESICULAR MONOAMINE TRANSPORT2 INHIBITOR	4	1	25.00%	3	75.00%
OPIATE AGONISTS	33	18	54.55%	15	45.45%
ANTIPRURITICS AND LOCAL ANESTHETICS	18	5	27.78%	13	72.22%
OTHER MISCELLANEOUS THERAPEUTIC AGENTS	1	0	0.00%	1	100.00%
VITAMIN K ACTIVITY	2	2	100.00%	0	0.00%
GI DRUGS, MISCELLANEOUS	7	3	42.86%	4	57.14%
IMMUNOSUPPRESSIVE AGENTS	2	1	50.00%	1	50.00%
NITRATES AND NITRITES	1	1	100.00%	0	0.00%
CALCIUM-CHANNEL BLOCKING AGENTS, MISC.	1	0	0.00%	1	100.00%
AMINOGLYCOSIDES	5	2	40.00%	3	60.00%
ANTIHISTAMINES (GI DRUGS)	15	7	46.67%	8	53.33%
REPLACEMENT PREPARATIONS	3	1	33.33%	2	66.67%
BENZODIAZEPINES (ANTICONVULSANTS)	9	3	33.33%	6	66.67%
5-HT3 RECEPTOR ANTAGONISTS	107	47	43.93%	60	56.07%
CENTRAL NERVOUS SYSTEM AGENTS, MISC.	6	4	66.67%	2	33.33%
SEL.SEROTONIN,NOREPI REUPTAKE INHIBITOR	31	10	32.26%	21	67.74%
ANTIALLERGIC AGENTS	13	1	7.69%	12	92.31%
BETA-ADRENERGIC BLOCKING AGENTS	2	0	0.00%	2	100.00%
DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS	1	0	0.00%	1	100.00%
BIGUANIDES	1	1	100.00%	0	0.00%
AMPHETAMINES	10	1	10.00%	9	90.00%
CENTRALLY ACTING SKELETAL MUSCLE RELAXNT	5	2	40.00%	3	60.00%
INSULINS	3	2	66.67%	1	33.33%
HEPARINS	11	9	81.82%	2	18.18%
IMMUNOMODULATORY AGENTS	5	4	80.00%	1	20.00%
RIFAMYCINS	3	1	33.33%	2	66.67%
BENZODIAZEPINES (ANXIOLYTIC,SEDATIV/HYP)	1	1	100.00%	0	0.00%
ATYPICAL ANTIPSYCHOTICS	95	47	49.47%	48	50.53%
PROTON-PUMP INHIBITORS	42	14	33.33%	28	66.67%
HCV POLYMERASE INHIBITORS	4	3	75.00%	1	25.00%
SEROTONIN MODULATORS	1	0	0.00%	1	100.00%
SCABICIDES AND PEDICULICIDES	26	14	53.85%	12	46.15%
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	29	16	55.17%	13	44.83%
SELECTIVE BETA-3-ADRENERGIC AGONISTS	1	1	100.00%	0	0.00%
ANTIDEPRESSANTS, MISCELLANEOUS	9	1	11.11%	8	88.89%

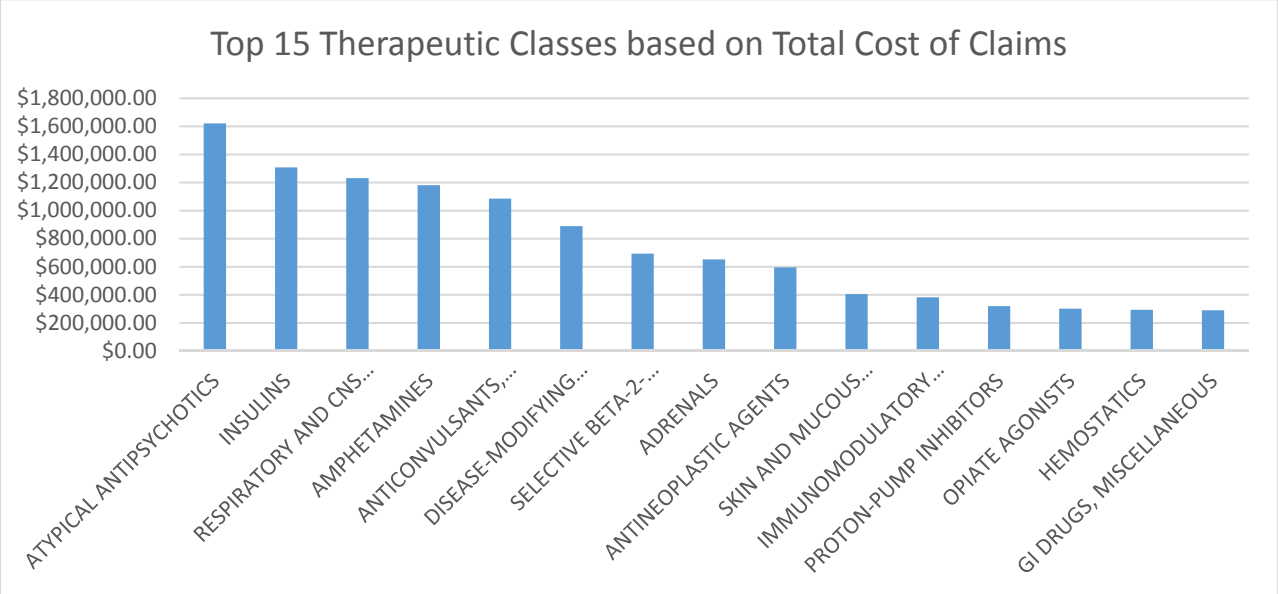
VASODILATING AGENTS (RESPIRATORY TRACT)	2	1	50.00%	1	50.00%
SELECTIVE BETA-2-ADRENERGIC AGONISTS	1	0	0.00%	1	100.00%
PHOSPHODIESTERASE TYPE 5 INHIBITORS	1	1	100.00%	0	0.00%
CORTICOSTEROIDS (EENT)	1	0	0.00%	1	100.00%
SKIN AND MUCOUS MEMBRANE AGENTS, MISC.	16	5	31.25%	11	68.75%
HISTAMINE H2-ANTAGONISTS	1	0	0.00%	1	100.00%
OPIATE PARTIAL AGONISTS	22	10	45.45%	12	54.55%
CONTRACEPTIVES	1	0	0.00%	1	100.00%
WAKEFULNESS-PROMOTING AGENTS	10	6	60.00%	4	40.00%
DIRECT FACTOR XA INHIBITORS	5	2	40.00%	3	60.00%
AZOLES (SKIN AND MUCOUS MEMBRANE)	1	1	100.00%	0	0.00%
SELECTIVE-SEROTONIN REUPTAKE INHIBITORS	15	6	40.00%	9	60.00%
PROTECTIVE AGENTS	1	1	100.00%	0	0.00%
CELL STIMULANTS AND PROLIFERANTS	2	1	50.00%	1	50.00%
ANGIOTENSIN II RECEPTOR ANTAGONISTS	2	1	50.00%	1	50.00%
DIHYDROPYRIDINES	1	1	100.00%	0	0.00%
RESPIRATORY AND CNS STIMULANTS	28	11	39.29%	17	60.71%
INCRETIN MIMETICS	3	3	100.00%	0	0.00%
SOMATOTROPIN AGONISTS	7	3	42.86%	4	57.14%
PROGESTINS	1	1	100.00%	0	0.00%
RESPIRATORY TRACT AGENTS, MISCELLANEOUS	5	3	60.00%	2	40.00%
SELECTIVE SEROTONIN AGONISTS	10	1	10.00%	9	90.00%
ERGOT-DERIV. DOPAMINE RECEPTOR AGONISTS	1	1	100.00%	0	0.00%
VITAMIN D	1	0	0.00%	1	100.00%
ANTICONVULSANTS, MISCELLANEOUS	65	28	43.08%	37	56.92%
ANTIGOUT AGENTS	2	1	50.00%	1	50.00%
ANXIOLYTICS,SEDATIVES,AND HYPNOTICS,MISC	10	4	40.00%	6	60.00%
SECOND GENERATION ANTIHISTAMINES	15	10	66.67%	5	33.33%
ALPHA-ADRENERGIC BLOCKING AGENTS	1	0	0.00%	1	100.00%
OTHER NONSTEROIDAL ANTI-INFLAM. AGENTS	2	1	50.00%	1	50.00%
ANTIMUSCARINICS	11	7	63.64%	4	36.36%
COMPOUND	1	0	0.00%	1	100.00%
ANTINEOPLASTIC AGENTS	5	3	60.00%	2	40.00%
CENTRAL ALPHA-AGONISTS	3	1	33.33%	2	66.67%
HCV PROTEASE INHIBITORS	4	2	50.00%	2	50.00%
LEUKOTRIENE MODIFIERS	2	1	50.00%	1	50.00%
PCSK9 INHIBITORS	3	0	0.00%	3	100.00%
TOTAL	**776**	**342**		**434**	

South Dakota Medicaid

Top 15 Therapeutic Class Profile Summary by Total Cost of Claims

Therapeutic Class Name	Rx	Paid	Paid/Rx	% Total Claims
ATYPICAL ANTIPSYCHOTICS	7,129	$1,620,876.25	$227.36	3.52%
INSULINS	2,767	$1,307,504.36	$472.54	1.37%
RESPIRATORY AND CNS STIMULANTS	6,883	$1,231,203.51	$178.88	3.40%
AMPHETAMINES	6,514	$1,181,102.92	$181.32	3.22%
ANTICONVULSANTS, MISCELLANEOUS	10,329	$1,085,698.37	$105.11	5.10%
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	229	$889,381.30	$3,883.76	0.11%
SELECTIVE BETA-2-ADRENERGIC AGONISTS	8,121	$693,186.90	$85.36	4.01%
ADRENALS	6,201	$651,479.62	$105.06	3.06%
ANTINEOPLASTIC AGENTS	343	$594,986.00	$1,734.65	0.17%
SKIN AND MUCOUS MEMBRANE AGENTS, MISC.	345	$404,940.05	$1,173.74	0.17%
IMMUNOMODULATORY AGENTS	44	$381,355.88	$8,667.18	0.02%
PROTON-PUMP INHIBITORS	6,028	$318,814.15	$52.89	2.98%
OPIATE AGONISTS	9,478	$301,376.97	$31.80	4.69%
HEMOSTATICS	23	$293,377.47	$12,755.54	0.01%
GI DRUGS, MISCELLANEOUS	272	$289,552.00	$1,064.53	0.13%
TOTAL TOP 15	64,706	$11,244,835.75	$173.78	31.97%

Total Rx Claims from 10/1/2017 to 12/31/2017	202,372



Top 50 Drugs Based on Number of Claims from 10/1/2017 to 12/31/2017

GPI Name	AHS Class Description	Rx	Paid Amount	Paid /Rx	% Total Claims
AMOXICILLIN (TRIHYDRATE)	AMINOPENICILLINS	6,972	$63,054.37	$9.04	3.45%
ALBUTEROL SULFATE	SELECTIVE BETA-2-ADRENERGIC AGONISTS	6,537	$305,162.84	$46.68	3.23%
METHYLPHENIDATE HCL	RESPIRATORY AND CNS STIMULANTS	5,251	$953,352.94	$181.56	2.59%
CETIRIZINE HCL	SECOND GENERATION ANTIHISTAMINES	4,049	$30,472.53	$7.53	2.00%
HYDROCODONE-ACETAMINOPHEN	OPIATE AGONISTS	4,024	$63,481.88	$15.78	1.99%
OMEPRAZOLE	PROTON-PUMP INHIBITORS	3,987	$34,604.26	$8.68	1.97%
FLUOXETINE HCL	SELECTIVE-SEROTONIN REUPTAKE INHIBITORS	3,881	$45,844.44	$11.81	1.92%
LEVOTHYROXINE SODIUM	THYROID AGENTS	3,421	$59,692.38	$17.45	1.69%
MONTELUKAST SODIUM	LEUKOTRIENE MODIFIERS	3,402	$44,636.40	$13.12	1.68%
SERTRALINE HCL	SELECTIVE-SEROTONIN REUPTAKE INHIBITORS	3,400	$26,078.22	$7.67	1.68%
LISDEXAMFETAMINE DIMESYLATE	AMPHETAMINES	3,394	$886,598.46	$261.23	1.68%
AZITHROMYCIN	OTHER MACROLIDES	3,035	$49,472.88	$16.30	1.50%
AMPHETAMINE-DEXTROAMPHETAMINE	AMPHETAMINES	2,974	$273,944.06	$92.11	1.47%
GABAPENTIN	ANTICONVULSANTS, MISCELLANEOUS	2,971	$61,097.68	$20.56	1.47%
TRAZODONE HCL	SEROTONIN MODULATORS	2,697	$16,737.37	$6.21	1.33%
LISINOPRIL	ANGIOTENSIN-CONVERTING ENZYME INHIBITORS	2,315	$15,612.32	$6.74	1.14%
GUANFACINE HCL	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	2,303	$70,937.18	$30.80	1.14%
LORATADINE	SECOND GENERATION ANTIHISTAMINES	2,254	$13,891.13	$6.16	1.11%
CLONIDINE HCL	CENTRAL ALPHA-AGONISTS	2,080	$16,205.43	$7.79	1.03%
TRAMADOL HCL	OPIATE AGONISTS	2,046	$19,330.22	$9.45	1.01%
METFORMIN HCL	BIGUANIDES	1,966	$29,897.82	$15.21	0.97%
FLUTICASONE PROPIONATE NASAL	CORTICOSTEROIDS (EENT)	1,876	$16,754.83	$8.93	0.93%
BUPROPION HCL	ANTIDEPRESSANTS, MISCELLANEOUS	1,748	$50,673.01	$28.99	0.86%
AMOXICILLIN & K CLAVULANATE	AMINOPENICILLINS	1,741	$46,233.64	$26.56	0.86%
PREDNISONE	ADRENALS	1,703	$11,787.64	$6.92	0.84%
CLONAZEPAM	BENZODIAZEPINES (ANTICONVULSANTS)	1,694	$12,217.76	$7.21	0.84%
ESCITALOPRAM OXALATE	SELECTIVE-SEROTONIN REUPTAKE INHIBITORS	1,675	$20,984.87	$12.53	0.83%
POLYETHYLENE GLYCOL 3350	CATHARTICS AND LAXATIVES	1,635	$41,170.20	$25.18	0.81%
GLUCOSE BLOOD TEST STRIP	DIABETES MELLITUS	1,628	$236,813.95	$145.46	0.80%
LAMOTRIGINE	ANTICONVULSANTS, MISCELLANEOUS	1,605	$118,336.98	$73.73	0.79%
ARIPIPRAZOLE	ATYPICAL ANTIPSYCHOTICS	1,593	$224,930.91	$141.20	0.79%
DEXMETHYLPHENIDATE HCL	RESPIRATORY AND CNS STIMULANTS	1,583	$256,728.56	$162.18	0.78%
QUETIAPINE FUMARATE	ATYPICAL ANTIPSYCHOTICS	1,583	$51,752.58	$32.69	0.78%
RISPERIDONE	ATYPICAL ANTIPSYCHOTICS	1,569	$21,568.78	$13.75	0.78%
ATORVASTATIN CALCIUM	HMG-COA REDUCTASE INHIBITORS	1,507	$14,534.21	$9.64	0.74%
CEPHALEXIN	FIRST GENERATION CEPHALOSPORINS	1,486	$21,653.67	$14.57	0.73%
SULFAMETHOXAZOLE-TRIMETHOPRIM	SULFONAMIDES (SYSTEMIC)	1,484	$26,945.52	$18.16	0.73%
CEFDINIR	THIRD GENERATION CEPHALOSPORINS	1,484	$56,978.47	$38.40	0.73%
IBUPROFEN	OTHER NONSTEROIDAL ANTI-INFLAM. AGENTS	1,389	$9,871.62	$7.11	0.69%
LORAZEPAM	BENZODIAZEPINES (ANXIOLYTIC,SEDATIV/HYP)	1,326	$9,020.59	$6.80	0.66%
DIVALPROEX SODIUM	ANTICONVULSANTS, MISCELLANEOUS	1,275	$70,771.70	$55.51	0.63%
CITALOPRAM HYDROBROMIDE	SELECTIVE-SEROTONIN REUPTAKE INHIBITORS	1,275	$7,044.33	$5.52	0.63%
CYCLOBENZAPRINE HCL	CENTRALLY ACTING SKELETAL MUSCLE RELAXNT	1,271	$13,421.92	$10.56	0.63%
TRIAMCINOLONE ACETONIDE	CORTICOSTEROIDS (SKIN, MUCOUS MEMBRANE)	1,251	$13,772.26	$11.01	0.62%
ERGOCALCIFEROL	VITAMIN D	1,245	$6,536.97	$5.25	0.62%
MIRTAZAPINE	ANTIDEPRESSANTS, MISCELLANEOUS	1,222	$13,731.31	$11.24	0.60%
VENLAFAXINE HCL	SEL.SEROTONIN,NOREPI REUPTAKE INHIBITOR	1,211	$31,934.14	$26.37	0.60%
RANITIDINE HCL	HISTAMINE H2-ANTAGONISTS	1,211	$12,547.66	$10.36	0.60%
LEVETIRACETAM	ANTICONVULSANTS, MISCELLANEOUS	1,198	$59,140.34	$49.37	0.59%
TOPIRAMATE	ANTICONVULSANTS, MISCELLANEOUS	1,167	$39,026.31	$33.44	0.58%
Total Claims 202,372	**Total for Top 50**	**115,594**	**$4,596,989.54**	**$39.77**	**57.12%**

Top 50 Drugs Based on Total Claims Cost from 10/1/2017 to 12/31/2017

GPI Name	AHS Class Description	Rx	Paid Amount	Paid /Rx	% Total Claims
METHYLPHENIDATE HCL	RESPIRATORY AND CNS STIMULANTS	5,251	$953,352.94	$181.56	2.59%
LISDEXAMFETAMINE DIMESYLATE	AMPHETAMINES	3,394	$886,598.46	$261.23	1.68%
INSULIN ASPART	INSULINS	989	$496,857.70	$502.38	0.49%
LURASIDONE HCL	ATYPICAL ANTIPSYCHOTICS	433	$487,015.15	$1,124.75	0.21%
ADALIMUMAB	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	86	$464,591.68	$5,402.23	0.04%
PALIPERIDONE PALMITATE	ATYPICAL ANTIPSYCHOTICS	171	$419,246.88	$2,451.74	0.08%
INSULIN GLARGINE	INSULINS	817	$330,780.70	$404.87	0.40%
ALBUTEROL SULFATE	SELECTIVE BETA-2-ADRENERGIC AGONISTS	6,537	$305,162.84	$46.68	3.23%
FLUTICASONE-SALMETEROL	SELECTIVE BETA-2-ADRENERGIC AGONISTS	767	$287,966.97	$375.45	0.38%
SOMATROPIN	SOMATOTROPIN AGONISTS	86	$282,005.71	$3,279.14	0.04%
PREGABALIN	ANTICONVULSANTS, MISCELLANEOUS	567	$275,723.43	$486.28	0.28%
AMPHETAMINE-DEXTROAMPHETAMINE	AMPHETAMINES	2,974	$273,944.06	$92.11	1.47%
CLOBAZAM	BENZODIAZEPINES (ANTICONVULSANTS)	199	$261,549.14	$1,314.32	0.10%
DEXMETHYLPHENIDATE HCL	RESPIRATORY AND CNS STIMULANTS	1,583	$256,728.56	$162.18	0.78%
ETANERCEPT	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	62	$252,921.35	$4,079.38	0.03%
GLUCOSE BLOOD TEST STRIP	DIABETES MELLITUS	1,628	$236,813.95	$145.46	0.80%
ARIPIPRAZOLE	ATYPICAL ANTIPSYCHOTICS	1,593	$224,930.91	$141.20	0.79%
IVACAFTOR	CYSTIC FIBROSIS (CFTR) POTENTIATORS	9	$224,557.74	$24,950.86	0.00%
FLUTICASONE PROPIONATE HFA	ADRENALS	878	$203,069.71	$231.29	0.43%
DORNASE ALFA	MUCOLYTIC AGENTS	57	$194,666.67	$3,415.20	0.03%
USTEKINUMAB	SKIN AND MUCOUS MEMBRANE AGENTS, MISC.	11	$188,999.67	$17,181.79	0.01%
LENALIDOMIDE	ANTINEOPLASTIC AGENTS	10	$172,741.97	$17,274.20	0.00%
LANSOPRAZOLE	PROTON-PUMP INHIBITORS	821	$168,723.41	$205.51	0.41%
ATOMOXETINE HCL	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	909	$168,159.82	$184.99	0.45%
INSULIN DETEMIR	INSULINS	351	$163,920.24	$467.01	0.17%
ANTIHEMOPHILIC FACTOR (RECOMBINANT)	HEMOSTATICS	6	$153,138.72	$25,523.12	0.00%
TEDUGLUTIDE (RDNA)	GI DRUGS, MISCELLANEOUS	4	$150,087.04	$37,521.76	0.00%
LACOSAMIDE	ANTICONVULSANTS, MISCELLANEOUS	178	$134,260.70	$754.27	0.09%
BUDESONIDE INHALATION	ADRENALS	402	$133,648.74	$332.46	0.20%
OXYCODONE HCL	OPIATE AGONISTS	1,132	$123,373.74	$108.99	0.56%
TETRABENAZINE	VESICULAR MONOAMINE TRANSPORT2 INHIBITOR	15	$121,923.33	$8,128.22	0.01%
TIOTROPIUM BROMIDE MONOHYDRATE	ANTIMUSCARINICS/ANTISPASMODICS	311	$120,188.44	$386.46	0.15%
PANCRELIPASE (LIP-PROT-AMYL)	DIGESTANTS	95	$119,390.68	$1,256.74	0.05%
LAMOTRIGINE	ANTICONVULSANTS, MISCELLANEOUS	1,605	$118,336.98	$73.73	0.79%
SITAGLIPTIN PHOSPHATE	DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS	280	$109,393.64	$390.69	0.14%
LUMACAFTOR-IVACAFTOR	CYSTIC FIBROSIS (CFTR) CORRECTORS	5	$109,220.32	$21,844.06	0.00%
ELTROMBOPAG OLAMINE	HEMATOPOIETIC AGENTS	12	$107,467.30	$8,955.61	0.01%
INSULIN LISPRO	INSULINS	184	$104,246.99	$566.56	0.09%
TOBRAMYCIN	AMINOGLYCOSIDES	26	$104,207.71	$4,007.99	0.01%
SOFOSBUVIR-VELPATASVIR	HCV POLYMERASE INHIBITORS	4	$104,076.92	$26,019.23	0.00%
INTERFERON GAMMA-1B	IMMUNOMODULATORY AGENTS	2	$99,415.47	$49,707.74	0.00%
ARIPIPRAZOLE LAUROXIL	ATYPICAL ANTIPSYCHOTICS	46	$97,626.29	$2,122.31	0.02%
IBRUTINIB	ANTINEOPLASTIC AGENTS	8	$92,740.35	$11,592.54	0.00%
RUFINAMIDE	ANTICONVULSANTS, MISCELLANEOUS	44	$92,466.92	$2,101.52	0.02%
LIRAGLUTIDE SOLN	INCRETIN MIMETICS	124	$91,713.64	$739.63	0.06%
TERIFLUNOMIDE	IMMUNOMODULATORY AGENTS	14	$87,922.94	$6,280.21	0.01%
BUDESONIDE-FORMOTEROL FUMARATE DIHYD	ADRENALS	285	$87,829.80	$308.17	0.14%
VIGABATRIN	ANTICONVULSANTS, MISCELLANEOUS	9	$87,251.89	$9,694.65	0.00%
INSULIN DEGLUDEC	INSULINS	159	$86,569.04	$544.46	0.08%
BREXPIPRAZOLE	ATYPICAL ANTIPSYCHOTICS	83	$82,435.18	$993.19	0.04%
Total Claims 202,372	**Total for Top 50**	**35,216**	**$10,899,962.43**	**$309.52**	**17.40%**

REVIEW OF DUZALLO® & ZURAMPIC®

PRODUCT DETAILS	**DUZALLO®** (lesinurad/allopurinol) A combination drug containing lesinurad, a URAT1 (uric acid transporter 1) inhibitor and allopurinol (xanthine oxidase inhibitor). Lesinurad works by helping the kidney excrete uric acid by inhibiting the function of transporter proteins involved in uric acid reabsorption in the kidney. Allopurinol reduces the production of uric acid.	**ZURAMPIC®** (lesinurad) URAT1 (uric acid transporter 1) inhibitor
INDICATIONS & USE	Treatment of hyperuricemia associated with gout in adults not achieving target serum uric acid levels with allopurinol alone.	Indicated in combination with a xanthine oxidase inhibitor for the treatment of hyperuricemia associated with gout in patients who have not achieved target serum uric acid levels with a xanthine oxidase inhibitor alone. Zurampic is not recommended for the treatment of asymptomatic hyperuricemia and should not be used as monotherapy.
DOSAGE & ADMINISTRA-TION	• Recommended dose is 1 tablet (containing lesinurad 200 mg; allopurinol 200 mg or 300 mg) once daily for patients who have not achieved target serum uric acid on allopurinol 300 mg/day or more. • Duzallo is not recommended for patients taking an allopurinol dose of less than 300 mg/day or for patients with asymptomatic hyperuricemia.	The dosage is 200 mg once daily in combination with a xanthine oxidase inhibitor, including allopurinol or febuxostat. The maximum daily dose is 200 mg. • Failure to take Zurampic with a xanthine oxidase inhibitor may increase the risk of renal adverse reactions • Zurampic tablets should be taken in the morning with food and water • Assess renal function before initiating Zurampic
DOSAGE FORMS & STRENGTHS	Tablets: • 200 mg lesinurad/200 mg allopurinol • 200 mg lesinurad/300 mg allopurinol	Tablet: • 200 mg
CONTRA-INDICATIONS	Duzalla carries a boxed warning for risk of acute renal failure. It should not be initiated in patients with an estimated creatinine clearance (eCrCl) less than 45mL/min. Duzallo is contraindicated in patients with the following conditions:	• Severe renal impairment, end stage renal disease, kidney transplant recipients, or patients on dialysis • Tumor lysis syndrome or Lesch-Nyhan syndrome

	• severe renal impairment, end stage renal disease, kidney transplant recipients, or patients receiving dialysis • a known hypersensitivity to allopurinol, including previous occurrence of skin rash or serious rash • tumor lysis syndrome (TLS) or Lesch-Nyhan syndrome, where the rate of uric acid formation is greatly increased	
	• Renal events • Skin rash & hypersensitivity • Hepatotoxicity • Cardiovascular events: major adverse cardiovascular events were observed with lesinurad; a causal relationship has not been established • Bone marrow suppression: bone marrow depression affecting one or more cell lines have been reported with allopurinol	• Renal events – Adverse reactions related to renal function have occurred after initiating Zurampic. A higher incidence was observed at the 400 mg dose, with the highest incidence occurring with monotherapy use. Monitor renal function at initiation and during therapy, particularly in patients with eCLcr below 60 mL/min, and evaluate for signs and symptoms of acute uric acid nephropathy. • Cardiovascular events – Major adverse cardiovascular events were observed with Zurampic; a causal relationship has not been established.
ADVERSE REACTIONS	The most common adverse reactions for lesinurad in combination with a xanthine oxidase inhibitor and more frequently than on xanthine oxidase inhibitor alone were headache, influenza, blood creatinine increased, and gastroesophageal reflux disease. The most frequently reported adverse reaction for allopurinol is skin rash.	Most common adverse reactions in 12-month controlled clinical trials (occurring in greater than or equal to 2% of patients treated with Zurampic in combination with a xanthine oxidase inhibitor and more frequently than on a xanthine oxidase inhibitor alone) were headache, influenza, blood creatinine increased, and gastroesophageal reflux disease.
DRUG INTERACTIONS	• *Mercaptopurine or Azathioprine:* Reduce mercaptopurine or azathioprine dose to approximately one-third to one-fourth of the usual dose and closely monitor for therapeutic response and the appearance of toxicity.	• Moderate CYP2C9 inhibitors – use with caution • Sensitive CYP3A substrates – monitor for efficacy of the CYP3A substrate

	• *Coumarin Anticoagulants:* Carefully monitor prothrombin time. • *Moderate Cytochrome P450 2C9 (CYP2C9) Inhibitors*: Use DUZALLO with caution. • *CYP3A Substrates*: Monitor for efficacy of the CYP3A substrate.	
USE IN SPECIAL POPULATIONS	*Renal impairment*: Not recommended for patients with eCrCl below 45 mL/min. *Hepatic impairment*: Not recommended for patients with severe hepatic impairment.	*Renal impairment*: Not recommended for patients with eCrCl below 45 mL/min. *Hepatic impairment*: Not recommended for patients with severe hepatic impairment.

CLASS OVERVIEW OF ANTI-GOUT AGENTS

Medication	Manufacturer	Availability	SDM Review
colchicine/probenecid	Various	Generic: 0.5mg/500mg tablet	
Colcrys (colchicine)	Takeda	Brand: 0.6mg tablet	
Duzallo (lesinurad/allopurinol**)**	Ironwood Pharmaceuticals	Brand: 200mg/200mg, 200mg/300 mg tablets	P&T 12/2017
Krystexxa (pegloticase)	Crealta	Brand: 8mg IV infusion	
Mitigare (colchicine)	Hikma Americas	Brand: 0.6mg capsule	
probenecid	Various	Generic: 500 mg tablet	
Uloric (febuxostat)	Takeda	Brand 40mg, 80mg tablets	PA
Zurampic (lesinurad)	AstraZeneca	Brand 200mg tablet	P&T 6/2016
Zyloprim (allopurinol)	Sebela Pharmaceuticals	Brand/Generic: 100mg, 300mg tablets	

References

1. Duzallo [package insert]. Cambridge, MA: Ironwood Pharmaceuticals, Inc; August 2017.
2. Clinical Pharmacology [online database]. Tampa, FL: Elsevier / Gold Standard, Inc. 2017. Available at www.clinicalpharmacology-ip.com. Accessed on November, 2017.
3. Lexicomp Online, Hudson, Ohio; Lexi-Comp, Inc.; 2017. Available at http://online.lexi.com. Accessed on November 2017
4. Zurampic [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals, LP; December 2015
5. Antigout TCR, OptumRx. Accessed on February 2017

Table of Contents

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Dispense As Written (DAW) Prior Authorization Request Form

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

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

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

Clinical Information (required)

Clinical information:

Has the patient had a trial and failure with the generic product? ❑ **Yes** ❑ **No**

Has the patient had a trial with the generic product and experienced an adverse reaction (a MedWatch form must be completed)? ❑ **Yes** ❑ **No**

Does the patient have a contraindication to the generic product? ❑ **Yes** ❑ **No**

Is the generic product unavailable? ❑ **Yes** ❑ **No**

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

_____

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: DAW_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

What is the patient's diagnosis for the medication being requested?

ICD-10 Code(s): _____

What medication(s) has the patient tried and failed?

Are there any supporting labs or test results? (Please specify)

Quantity limit requests:
What is the quantity requested per DAY? _____
What is the reason for exceeding the plan limitations?
- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Patient requires a greater quantity for the treatment of a larger surface area **[Topical applications only]**
- ❑ Other: _____

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

_____

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_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: General_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Quantity Limit Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

What is the patient's diagnosis for the medication being requested?

ICD-10 Code(s): _____

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Patient requires a greater quantity for the treatment of a larger surface area **[Topical applications only]**
- ❑ Other: _____

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

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: MaxUnitsOverride_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

High Dollar/Claim Dollar Amount Override Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

What is the patient's diagnosis for the medication being requested?

ICD-10 Code(s): _____

What is the requested quantity per day/fill/prescription/ or month? _____
Please indicate the daily dosages and the quantity requested per prescription/fill/ or month and the duration (i.e., 3 capsules per day, 4 capsules per prescription/per 30 days). Use/take as directed is not sufficient information.

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

_____

_____

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: HighDollar-ClaimDollarOverride_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Grastek®, Oralair®, Ragwitek® Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

What is the patient's diagnosis for the medication being requested? (Mandatory)

_____

ICD-10 Code(s): _____

Clinical information:

Is the patient's diagnosis confirmed by a positive skin test or in vitro testing for pollen-specific IgE antibodies? ❑ **Yes** ❑ **No**
Has the patient had a history of failure or intolerance to subcutaneous allergen immunotherapy (allergy shots)? ❑ **Yes** ❑ **No**
Does the patient have severe, unstable or uncontrolled asthma? ❑ **Yes** ❑ **No**

Select the medication categories that the patient has tried and failed:

- ❑ Intranasal antihistamines (e.g., azelastine, olopatadine, azelastine/fluticasone)
- ❑ Intranasal corticosteroids (e.g., beclomethasone, budesonide, ciclesonide, flunisolide, fluticasone, mometasone, triamcinolone)
- ❑ Leukotriene inhibitors (e.g., montelukast, zafirlukast, zileuton)
- ❑ Oral antihistamines (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, or loratadine)

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

_____

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_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: OralAllergenExtracts_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Altabax® Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Methicillin resistant Staphylococcus aureus (MRSA)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Medication history:

Has the patient tried and failed generic mupirocin ointment or cream for a minimum of 5 days within the last 90 days? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

❑ Patient requires a larger quantity to cover a larger surface area

❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Altabax_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Eliquis®, Pradaxa®, Savaysa®, Xarelto®
Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

What is the patient's diagnosis for the medication being requested? (Mandatory)

_____

ICD-10 Code(s) [Mandatory]: _____

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

_____

_____

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Anticoagulants_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Antidepressants Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

What is the patient's diagnosis for the medication being requested? _____

ICD-10 Code(s): _____

Clinical information:

Is the patient already stabilized on therapy with the requested medication? ❑ **Yes** ❑ **No**

Please list ALL medications the patient has had a trial within the past 12 months:_____

_____

For Lexapro solution, Paxil suspension, Prozac solution, Remeron SolTab, and Zoloft concentrate requests, also answer the following:

Does the patient have a diagnosis which confirms a difficulty in swallowing? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Brisdelle™ Prior Authorization Request Form

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

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

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

Clinical Information (required)

Medication history:

Has the patient had a 60 day trial and failure of paroxetine oral tablets within the past 6 months? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Brisdelle_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Atypical Antipsychotics Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Continuation of therapy:
Is this for a continuation of a second generation atypical antipsychotic agent? ❑ **Yes** ❑ **No**

What is the patient's diagnosis for the medication being requested? (Mandatory)

_____

ICD-10 Code(s) [Mandatory]: _____

Clinical information:
For patients with a diagnosis of depression, has the patient tried and failed 2 different antidepressants? ❑ **Yes** ❑ **No**
For patients younger than 6 years of age, is a psychiatrist, developmental pediatrician, child/adolescent psychiatrist or pediatric neurologist involved in care? ❑ **Yes** ❑ **No**

For alternative dosage forms (e.g., rapid dissolve tablets, injectables, extended-release), also answer the following:
Is the patient unable to swallow? ❑ **Yes** ❑ **No**
Has the patient failed a standard dosage form from this drug class in the last 30 days? ❑ **Yes** ❑ **No**

Quantity limit requests:
What is the quantity requested per DAY? _____
What is the reason for exceeding the plan limitations?
❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: AtypicalAntipsychotics_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Akynzeo® Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ Prophylaxis of chemotherapy-induced nausea/vomiting

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Has the patient received highly emetogenic chemotherapy regimens or regimens including anthracyclines and cyclophosphamide in the past 90 days? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Diclegis® Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ Hyperemesis gravidarum

❑ Other diagnosis: _____ ICD-10 Code(s): _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Diclegis_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Sancuso® Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Prophylaxis of chemotherapy-induced nausea/vomiting

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Has the patient had a trial of a generic -Hydroxytryptamine type 3 (5-HT3) receptor antagonist for 14 days in the past 90 days? ❑ **Yes** ❑ **No**

Is the patient receiving moderately and/or highly emetogenic chemotherapy for up to 5 consecutive days? ❑ **Yes** ❑ **No**

Is the patient unable to tolerate oral medications for chemotherapy-induced nausea and vomiting due to a diagnosis of difficulty swallowing? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Sancuso_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Zuplenz® Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Clinical information:

Has the patient had a trial of a generic -Hydroxytryptamine type 3 (5-HT3) receptor antagonist for 14 days in the past 90 days? ❑ **Yes** ❑ **No**

Is the patient receiving moderately and/or highly emetogenic chemotherapy for up to 5 consecutive days? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Zuplenz_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Non-sedating Antihistamines Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:
- ❑ Chronic idiopathic urticaria
- ❑ Perennial allergic rhinitis
- ❑ Seasonal allergic rhinitis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Medication history:

Has the patient tried and failed a 14-day trial of one of the following: Cetirizine, cetirizine & pseudoephedrine, fexofenadine, fexofenadine & pseudoephedrine, loratadine, or loratadine & pseudoephedrine? ❑ **Yes** ❑ **No**

Please note: Patient preference does NOT constitute treatment failure.

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?
- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: NonSedatingAntihistamines_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Non-sedating Antihistamines (chewable, liquid, orally disintegrating tablet [ODT] formulations) Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:
- ❑ Chronic idiopathic urticaria
- ❑ Perennial allergic rhinitis
- ❑ Seasonal allergic rhinitis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Does the patient have a documented difficulty in swallowing diagnosis? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?
- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Chewable-Liquid-ODT-NonSedatingAntihistamines_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Edarbi and Edarbyclor Prior Authorization Request Form

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

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

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

Clinical Information (required)

Clinical information:

Has the patient been stable on the requested angiotensin II receptor blocker (ARB) for more than 60 days? ❑ **Yes** ❑ **No**

Has the patient tried an angiotensin-converting enzyme (ACE) inhibitor or a generic ARB within the last 120 days? ❑ **Yes** ❑ **No**

Does the patient have an additional diagnosis of chronic obstructive pulmonary disease (COPD) or acute/chronic renal failure? ❑ **Yes** ❑ **No**

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

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: ARBS_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Byvalson™ Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ Hypertension

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Medication history:

Has the patient had a trial of concurrent use of nebivolol plus generic valsartan for at least 90 days? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Byvalson_SouthDakotaMedicaid_2017Nov-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Amrix® & Fexmid® (cyclobenzaprine) Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ Adjunct to rest and physical therapy for relief of muscle spasm associated with acute, painful musculoskeletal conditions

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Medication history:

Has the patient had at least a 60 day trial and failure of cyclobenzaprine 5 mg tablets **OR** cyclobenzaprine 10 mg tablets within the past 120 days? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Amrix-Fexmid-cyclobenzaprine_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Cambia®, Zipsor®, Zorvolex® Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Medication history:

Has the patient had a documented 30 day trial of a generic diclofenac product within the last 120 days? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Cambia-Zipsor-Zorvolex_SouthDakotaMedicaid_2017Nov-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Amitiza®, Linzess®, Movantik™ Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

- ❑ Chronic idiopathic constipation [**Amitiza** and **Linzess** only]
- ❑ Irritable bowel syndrome with constipation (IBS-C) [**Amitiza** and **Linzess** only]
- ❑ Opioid-induced constipation in an adult patient with chronic pain [**Amitiza** and **Movantik** only]
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

For opioid-induced constipation in an adult patient with chronic pain, answer the following:

Is the pain associated with cancer? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Amitiza-Linzess-Movantik_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Desoxyn® (methamphetamine) Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ Attention Deficit Disorder with Hyperactivity

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Medication history:

Has the patient had a trial and failure (after a mimimum of a 60 day trial), contraindication, or intolerance to any four medications from any of the following options in the past 90 days? ❑ **Yes** ❑ **No**

- Atomoxetine
- Guanfacine
- Long-acting amphetamine salts product
- Long-acting methylphenidate product

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Dificid® Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Clostridium difficile-associated diarrhea (CDAD)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Has the patient been treated per the current guidelines? ❑ **Yes** ❑ **No**

Select the following that the patient has 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

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Dificid_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Dupixent® Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ Atopic dermatitis

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Has the patient had a documented trial of topical corticosteroid within the last 120 days? ❑ **Yes** ❑ **No**

Was the medication prescribed by or in consultation with a dermatologist or allergist/immunologist? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Dupixent_SouthDakotaMedicaid_2017Nov-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Durlaza™ Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

- ❑ Chronic coronary artery disease (CAD)
- ❑ Ischemic stroke
- ❑ Transient ischemic attack
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Has the patient had a 90 day trial and failure with immediate release aspirin? ❑ **Yes** ❑ **No**

Please submit clinical rationale explaining why a failure with the extended-release product is not expected:

_____

_____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Durlaza_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Emflaza™ Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Duchenne muscular dystrophy

❑ Other diagnosis: _____ ICD-10 Code(s): _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Emflaza_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Genitourinary smooth muscle relaxants Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

What is the patient's diagnosis for the medication being requested? (Mandatory)

_____

ICD-10 Code(s) [Mandatory]: _____

Medication history:

Has the patient had a 30-day trial of oxybutynin or oxybutynin extended-release (ER) within the last 4 months? ❑ **Yes** ❑ **No**

For Gelnique and Oxytrol requests, also answer the following:

Does the patient have a diagnosis which confirms a difficulty in swallowing? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: GenitourinarySmoothMuscleRelaxants_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

GLP-1 Agonists Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ Type 2 diabetes mellitus

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Gralise® & Horizant® Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

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

Moderate to severe primary RLS:

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

Neuropathic pain associated with PHN:

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

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Gralise-Horizant_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Growth Hormones Prior Authorization Request Form (Page 1 of 3)

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

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

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

Clinical Information (required)

Select the requested medication below:

- ❑ Genotropin
- ❑ Humatrope
- ❑ Norditropin
- ❑ Nutropin AQ
- ❑ Omnitrope
- ❑ Saizen
- ❑ Zomacton

Select the diagnosis below:

For Pediatric Patients (less than 18 years of age):

- ❑ Growth hormone deficiency in children
- ❑ Growth failure due to chronic renal insufficiency
- ❑ Growht failure due to panhypopituitarism
- ❑ Growth failure due to Prader-Willi syndrome
- ❑ Idiopathic short stature in children
- ❑ Noonan syndrome
- ❑ Short stature homeobox containing gene (SHOX) deficiency
- ❑ Small for gestational age
- ❑ Turner syndrome

For Adults (18 years of age or older):

- ❑ Growth hormone deficiency in adults
- ❑ Panhypopituitarism
- ❑ Prader-Willi syndrome
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Contraindications/Exclusions:

Does the patient have acute critical illness due to complications following open heart surgery, abdominal surgery, multiple accidental trauma, or acute respiratory failure? ❑ **Yes** ❑ **No**

Does the patient have active malignancy? ❑ **Yes** ❑ **No**

Does the patient have active proliferative or severe non-proliferative diabetic retinopathy? ❑ **Yes** ❑ **No**

DSS
Strong Families - South Dakota's Foundation and Our Future

Growth Hormones Prior Authorization Request Form (Page 2 of 3)

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

For Pediatric Patients (less than 18 years of age):

Is the requested medication prescribed by or in consultation with a pediatric endocrinologist? ❑ **Yes** ❑ **No**

Are the patient's epiphyses open? ❑ **Yes** ❑ **No**

Has the patient been screen for intracranial malignancy or tumor? ❑ **Yes** ❑ **No**

For growth hormone deficiency in children, also answer the following:

Has growth hormone deficiency been confirmed with provocative test and/or IGF-1 levels? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response to two (2) pharmacological growth hormone stimulation tests* with peak level below 10 ng/mL? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response to at least one (1) pharmacological growth hormone stimulation test* with peak level below 10 ng/mL for a patient with defined CNS pathology, multiple pituitary hormone deficiencies, history of irradiation, or proven genetic cause? ❑ **Yes** ❑ **No**

**Please note: acceptable tests include: arginine, clonidine, glucagon, insulin, and levodopa*

Is the patient's height more than 3 standard deviations (SDs) below the mean for same age and gender? ❑ **Yes** ❑ **No**

Is the patient's height more than 2 SDs below the mean for same age and gender AND the patient has decreased growth velocity more than 1 SD below the mean for the same age and gender? ❑ **Yes** ❑ **No**

Is the patient's growth velocity measured 2 SDs below the mean over one year or 1.5 SDs below the mean sustained over 2 years for the same age and gender? ❑ **Yes** ❑ **No**

Have other causes of growth failure been ruled out (e.g., hypothyroidism, chronic systemic disease, skeletal disorders, malnutrition)? ❑ **Yes** ❑ **No**

For growth failure due to chronic renal insufficiency, also answer the following:

Has the patient's nutritional status been optimized and metabolic abnormalities been corrected? ❑ **Yes** ❑ **No**

Has the patient had a kidney transplant? ❑ **Yes** ❑ **No**

Is the patient's height less than the 3rd percentile? ❑ **Yes** ❑ **No**

Is the patient's growth velocity measured over 1 year > 2 standard deviations below the mean for same age and gender? ❑ **Yes** ❑ **No**

For growth failure due to panhypopituitarism or Prader-Willi syndrome, also answer the following:

Has the patient's diagnosis of panhypopituitarism or Prader-Willi syndrome been confirmed by appropriate genetic testing? ❑ **Yes** ❑ **No**

Does the patient have severe obesity, history of upper airway obstruction or sleep apnea, or severe respiratory impairment? ❑ **Yes** ❑ **No**

Is the patient's height more than 2 standard deviations below the mean for same age and gender? ❑ **Yes** ❑ **No**

For idiopathic short stature, also answer the following:

Is the patient's height more than 2.25 standard deviations below the mean for same age and gender? ❑ **Yes** ❑ **No**

Is the patient's predicted height less than or equal to 65 inches for male or less than or equal to 60 inches for females? ❑ **Yes** ❑ **No**

For short stature homeobox-containing gene (SHOX) deficiency or Noonan syndrome, also answer the following:

Is the patient's height more than 3 standard deviations (SDs) below the mean for same age and gender? ❑ **Yes** ❑ **No**

Is the patient's height more than 2 SDs below the mean for same age and gender AND the patient has decreased growth velocity more than 1 SD below the mean for the same age and gender? ❑ **Yes** ❑ **No**

Is the patient's growth velocity measured 2 SDs below the mean over one year or 1.5 SDs below the mean sustained over 2 years for the same age and gender? ❑ **Yes** ❑ **No**

For small for gestation age (SGA), also answer the following:

Is the patient below the 5th percentile for height? ❑ **Yes** ❑ **No**

Was the patient's birth weight or length at least 2 standard deviations below the mean for gestational age? ❑ **Yes** ❑ **No**

For Turner's syndrome, also answer the following:

Has the patient's diagnosis of Turner's syndrome been confirmed by chromosome analysis? ❑ **Yes** ❑ **No**

Is the patient's height less than the 5th percentile for same age and gender? ❑ **Yes** ❑ **No**

DSS
Strong Families - South Dakota's Foundation and Our Future

Growth Hormones Prior Authorization Request Form (Page 3 of 3)

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

For Adult Patients (18 years of age or older):

Is the requested medication prescribed by or in consultation with a endocrinologist? ❑ **Yes** ❑ **No**

For growth hormone deficiency in adults, also answer the following:

Has growth hormone deficiency been confirmed with two provocative tests and IGF-1 levels? ❑ **Yes** ❑ **No**

Has the patient been screen for intracranial malignancy or tumor? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: GrowthHormones_SouthDakotaMedicaid_2017May-W

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Serostim® Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ HIV infection/AIDs wasting

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is Serostim prescribed by or in consultation with an infectious disease specialist? ❑ **Yes** ❑ **No**

Has the patient tried and had inadequate response or intolerance to dronabinol or megestrol? ❑ **Yes** ❑ **No**

Is the patient currently receiving treatment with antiretrovirals? ❑ **Yes** ❑ **No**

Does the patient have acute critical illness due to complications following open heart surgery, abdominal surgery, multiple accidental trauma, or those with acute respiratory failure? ❑ **Yes** ❑ **No**

Has the patient been screened to verify the absence of any active malignancy? ❑ **Yes** ❑ **No**

Does the patient have active proliferative or severe non-proliferative diabetic retinopathy? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Serostim_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Zorbtive® Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ Short bowel syndrome

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is Zorbtive prescribed by or in consultation with a gastroenterologist? ❑ **Yes** ❑ **No**

Is the patient receiving specialized nutritional support (i.e., parenteral nutrition)? ❑ **Yes** ❑ **No**

Does the patient have acute critical illness due to complications following open heart surgery, abdominal surgery, multiple accidental trauma, or acute respiratory failure? ❑ **Yes** ❑ **No**

Has the patient been screened to verify the absence of any active malignancy? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Zorbtive_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Lindane shampoo, Ovide® (malathion), Natroba™ (spinosad), Sklice®
Prior Authorization Request Form

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

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

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

Clinical Information (required)

Medication history:

Has the patient had a trial and failure, contraindication, or intolerance to a permethrin or pyrethrins-piperonyl butoxide product in the past 90 days? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: LindaneShampoo-Ovide-malathion-Natroba-spinosad-Sklice_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Hemangeol™ Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ Proliferating infantile hemangioma requiring systemic therapy

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is the patient's weight 2 kilograms (kg) or greater? ❑ **Yes** ❑ **No**

Does the patient have asthma or a history of bronchospasm? ❑ **Yes** ❑ **No**

Does the patient have bradycardia (less than 80 beats per minute)? ❑ **Yes** ❑ **No**

Does the patient have greater than first-degree heart block, decompensated heart failure? ❑ **Yes** ❑ **No**

Does the patient have blood pressure less than 50/30 mmHg? ❑ **Yes** ❑ **No**

Does the patient have pheochromocytoma? ❑ **Yes** ❑ **No**

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

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Hemangeol_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Hepatitis C Prior Authorization Request Form (Page 1 of 3)

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

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

Medication Information (required)

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

Clinical Information (required)

Select the medication being requested:

❑ Daklinza® ❑ Harvoni® ❑ Sovaldi® ❑ Viekira Pak®, Viekira XR®
❑ Epclusa® ❑ Olysio® ❑ Technivie® ❑ Zepatier®

Select the diagnosis below:

❑ Hepatitis C virus infection
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Document the patient's genotype: _____

Select if the patient has the following:

❑ Liver biopsy confirming a Metavir score of F3 or F4, unless medically contraindicated
❑ Serum aspartate aminotransferase (AST)-to-platelet ration index (APRI) score of 2 or greater
❑ Fibroscan score of 10 or greater

Does the patient have cirrhosis? ❑ **Yes** ❑ **No**

Does the patient have compensated liver disease? ❑ **Yes** ❑ **No**

Is there documentation the patient has severe extrahepatic manifestions of hepatitis c infection? ❑ **Yes** ❑ **No**

Is the requested medication prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist? ❑ **Yes** ❑ **No**

Does the provider attest that the patient is drug and alcohol free for the past 6 months? ❑ **Yes** ❑ **No**

If the patient is female and prescribed ribavirin, does the patient have a negative pregnancy test within 30 days prior to initiation of therapy and will receive a monthly pregnancy test during treatment? ❑ **Yes** ❑ **No**

For Daklinza, also answer the following:

Will Daklinza be used in combination with Sovaldi (sofosbuvir), with or without ribavirin? ❑ **Yes** ❑ **No**

Is the patient taking strong inducers of cytochrome P450 (CYP) 3A (e.g., phenytoin, carbamazepine, rifampin, St. John's wort)? ❑ **Yes** ❑ **No**

For Epclusa, also answer the following:

Is the patient taking P glycoprotein (P-gp) inducers? ❑ **Yes** ❑ **No**

Is the patient taking moderate to potent CYP inducers (e.g., carbamazepine, rifampin, St. John's wort)? ❑ **Yes** ❑ **No**

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Hepatitis C Prior Authorization Request Form (Page 2 of 3)

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

For Harvoni, also answer the following:

Is the patient treatment naïve? ❑ **Yes** ❑ **No**

Does the patient have severe renal impairment (eGFR < 30 mL/min/1.73 m^2)? ❑ **Yes** ❑ **No**

Does the patient have end stage renal disease? ❑ **Yes** ❑ **No**

Select if the patient is taking any of the following mediations:

❑ P glycoprotein (P-gp) inducers (e.g., rifampin, St. John's wort)

❑ Carbamazepine ❑ Phenobarbital ❑ Rosuvastatin ❑ Tipranavir/ritonavir
❑ Oxcarbazepine ❑ Phenytoin ❑ Tenofovir-containing HIV regimens

For Olysio, also answer the following:

Does the patient have the NS3 Q80K polymorphism? ❑ **Yes** ❑ **No**

Will Olysio be used in combination with Sovaldi? ❑ **Yes** ❑ **No**

Will Olysio be used in combination with pegylated interferon and ribavirin? ❑ **Yes** ❑ **No**

Is the patient taking strong inducers of cytochrome P450 (CYP) 3A (e.g., phenytoin, carbamazepine, rifampin, St. John's wort)? ❑ **Yes** ❑ **No**

For Sovaldi, also answer the following:

Select if the patient will use Sovaldi in combination with the following:

❑ Daklinza (daclatasvir)
❑ Olysio (simeprevir)
❑ Pegylated interferon and ribavirin
❑ Ribavirin

Does the patient have severe renal impairment (eGFR < 30 mL/min/1.73 m^2)? ❑ **Yes** ❑ **No**

Does the patient have end stage renal disease? ❑ **Yes** ❑ **No**

Does the patient have hepatocellular carcinoma that meets criteria for liver transplant? ❑ **Yes** ❑ **No**

For Technivie, also answer the following:

Will Technivie be used in combination with ribavirin? ❑ **Yes** ❑ **No**

Is the patient taking moderate to strong inducers of CYP3A or drugs that are highly dependent on CYP3A for clearance? ❑ **Yes** ❑ **No**

Does the patient have moderate to severe hepatic impairment? ❑ **Yes** ❑ **No**

For Viekira, also answer the following:

Does the patient have moderate to severe hepatic impairment (Child-Pugh B and C)? ❑ **Yes** ❑ **No**

Is the patient a liver transplant recipient with normal hepatic function and mild fibrosis? ❑ **Yes** ❑ **No**

Select if the patient is taking Viekira with any of the following mediations:

❑ Alpha 1-adrenoreceptor antagonist (alfuzosin)
❑ Anti-gout (colchicine)
❑ Anticonvulsants (carbamazepine, phenytoin, phenobarbital)
❑ Antihyperlipidemic agent (gemfibrozil)
❑ Antimycobacterial (rifampin)
❑ Cisapride
❑ Ergot derivatives (ergotamine, dihydroergotamine, methylergonovine)
❑ Ethinyl estradiol containing products (e.g., combined oral contraceptives)
❑ Herbal products (St. John's wort)
❑ HMG-CoA reductase inhibitors (lovastatin, simvastatin)
❑ Lurasidone
❑ Neuroleptics (pimozide)
❑ Non-nucleoside reverse transcriptase inhibitor (efavirenz)
❑ Phosphodiesterase-5 inhibitor (sildenafil; when administered for pulmonary arterial hypertension)
❑ Ranolazine
❑ Sedative/hypnotics (triazolam, orally administered midazolam)

For Zepatier, also answer the following:

Has the patient been tested for the presence of NS5A resistance-associated polymorphisms? ❑ **Yes** ❑ **No**

If yes to the above question, does the patient have baseline NS5A polymorphisms? ❑ **Yes** ❑ **No**

Does the patient have moderate to severe hepatic impairment (Child-Pugh B and C)? ❑ **Yes** ❑ **No**

Has the patient failed the 2-drug regimen of peginterferon alfa and ribavirin? ❑ **Yes** ❑ **No**

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Hepatitis C Prior Authorization Request Form (Page 3 of 3)

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

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Hydrocodone-acetaminophen (APAP) Products Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Medication history:

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

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

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Brand Name narcotics Prior Authorization Request Form

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

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

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

Clinical Information (required)

Medication history:

Has the patient had a trial and failure (at least a 30 day trial) of a generic narcotic in the past 90 days? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the patient's diagnosis for the medication being requested?

_____ ICD-10 Code(s): _____

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Methadone Products Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Clinical information:

Is the patient being prescribed methadone for the treatment of chronic severe pain? ❑ **Yes** ❑ **No**

Is the patient unable to take all other long-acting opioids? ❑ **Yes** ❑ **No**

Is the requested medication being prescribed on a scheduled basis, not just as needed? ❑ **Yes** ❑ **No**

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

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Bunavail™, buprenorphine sublingual (SL) tablet, buprenorphine-naloxone SL tablet, Suboxone®, Zubsolv® Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:
❑ Treatment of documented opioid dependence
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Provider registration:
Is the provider registered to prescribe buprenorphine/buprenorphine-naloxone under the Substance Abuse and Mental Health Services Administration (SAMHSA)? ❑ **Yes** ❑ **No**

Clinical information:
Is the patient taking other opioids, tramadol or carisoprodol? ❑ **Yes** ❑ **No**
If **yes,** will the patient be weaned off prior to initiation of therapy of the requested medication? ❑ **Yes** ❑ **No**

Quantity limit requests:
What is the quantity requested per DAY? _____
What is the reason for exceeding the plan limitations?
❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

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

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: OpioidDependence_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Evzio™ Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Clinical information:

Is the patient currently receiving greater than 100 mg of a morphine equivalent dose (MED) per day? ❑ **Yes** ❑ **No**

Select if the patient is currently taking opioids with other interacting medication(s) from one of the following classes:

❑ Benzodiazepines
❑ Central muscle relaxants
❑ Opiods

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

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Evzio_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Esbriet® & Ofev® Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ Idiopathic pulmonary fibrosis (IPF)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Does the patient have a forced vital capacity (FVC) greater than or equal to 50% of predicted in the last 60 days? ❑ **Yes** ❑ **No**

Is the requested medication prescribed by or in consultation with a pulmonologist? ❑ **Yes** ❑ **No**

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

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Esbriet-Ofev_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Actemra® Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

- ❑ Active polyarticular juvenile idiopathic arthritis (pJIA)
- ❑ Active systemic juvenile idiopathic arthritis (sJIA)
- ❑ Moderately to severely active rheumatoid arthritis (RA) – Actemra pre-filled syringe only
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is the requested medication prescribed by or in consultation with a rheumatologist? ❑ **Yes** ❑ **No**
Will the requested medication be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

For active polyarticular juvenile idiopathic arthritis (pJIA), also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs)? ❑ **Yes** ❑ **No**

For systemic juvenile idiopathic arthritis (sJIA), also answer the following:

Has the patient had an inadequate response or intolerance to at least one oral systemic agent [i.e., non-steroidal anti-inflammatory drugs (NSAIDs), corticosteroid]? ❑ **Yes** ❑ **No**

For moderately to severely active rheumatoid arthritis (RA), also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs)? ❑ **Yes** ❑ **No**

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

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Actemra_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Cimzia® Prior Authorization Request Form (Page 1 of 2)

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Active ankylosing spondylitis
❑ Active psoriatic arthritis
❑ Moderately to severely active Crohn's disease
❑ Moderately to severely active rheumatoid arthritis
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Select if the requested medication is prescribed by or in consultation with one of the following specialists:
❑ Dermatologist ❑ Gastroenterologist ❑ Rheumatologist

Will the requested medication be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

For active ankylosing spondylitis, also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to one or more non-steroidal anti-inflammatory drugs (NSAIDs)? ❑ **Yes** ❑ **No**

For active psoriatic arthritis, also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to methotrexate? ❑ **Yes** ❑ **No**

For moderately to severely active Crohn's disease, also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to one or more immunosuppressive agents (e.g., azathioprine, mercaptopurine, methotrexate)? ❑ **Yes** ❑ **No**

For moderately to severely active rheumatoid arthritis, also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs)? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Patient requires a greater quantity for the treatment of a larger surface area **[Topical applications only]**
❑ Other: _____

Office use only: Cimzia_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Cimzia® Prior Authorization Request Form (Page 2 of 2)

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

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

_____

_____

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Cimzia_SouthDakotaMedicaid_2017May-W

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Cosentyx® Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Active ankylosing spondylitis
❑ Active psoriatic arthritis
❑ Moderate to severe plaque psoriasis
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Select if the requested medication is prescribed by or in consultation with one of the following specialists:
❑ Dermatologist ❑ Rheumatologist

Will the requested medication be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

For active ankylosing spondylitis, also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to one or more non-steroidal anti-inflammatory drugs (NSAIDs)? ❑ **Yes** ❑ **No**

For active psoriatic arthritis, also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to methotrexate? ❑ **Yes** ❑ **No**

For moderate to severe plaque psoriasis, also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to conventional therapy with at least one of the following: phototherapy or one or more oral systemic treatments (i.e., methotrexate, cyclosporine, acitretin, sulfasalazine)? ❑ **Yes** ❑ **No**

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

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Cosentyx_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Enbrel® Prior Authorization Request Form (Page 1 of 2)

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

- ❑ Active ankylosing spondylitis (AS)
- ❑ Active psoriatic arthritis (PsA)
- ❑ Moderate to severe chronic plaque psoriasis (PsO)
- ❑ Moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA)
- ❑ Moderately to severely active rheumatoid arthritis (RA)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Select if the requested medication is prescribed by or in consultation with one of the following specialists:

- ❑ Dermatologist
- ❑ Rheumatologist

Will the requested medication be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

For active ankylosing spondylitis (AS), also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to one or more non-steroidal anti-inflammatory drugs (NSAIDs)? ❑ **Yes** ❑ **No**

For active psoriatic arthritis (PsA), also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to methotrexate? ❑ **Yes** ❑ **No**

For moderate to severe plaque psoriasis (PsO), also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to conventional therapy with at least one of the following: phototherapy or one or more oral systemic treatments (i.e., methotrexate, cyclosporine, acitretin, sulfasalazine)? ❑ **Yes** ❑ **No**

For moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA), also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs)? ❑ **Yes** ❑ **No**

For moderately to severely active rheumatoid arthritis (RA), also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs)? ❑ **Yes** ❑ **No**

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Enbrel® Prior Authorization Request Form (Page 2 of 2)

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

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Patient requires a greater quantity for the treatment of a larger surface area **[Topical applications only]**
- ❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Enbrel_SouthDakotaMedicaid_2017May-W

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Humira® Prior Authorization Request Form (Page 1 of 2)

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

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

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

Clinical Information (required)

Select the diagnosis below:

- ❑ Active ankylosing spondylitis
- ❑ Active psoriatic arthritis (PsA)
- ❑ Moderate to severe chronic plaque psoriasis
- ❑ Moderate to severe hidradenitis suppurativa (e.g., Hurley Stage II or III)
- ❑ Moderately to severely active Crohn's disease
- ❑ Moderately to severely active polyarticular juvenile idiopathic arthritis (JIA)
- ❑ Moderately to severely active rheumatoid arthritis (RA)
- ❑ Moderately to severely active ulcerative colitis
- ❑ Non-infectious uveitis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Select if the requested medication is prescribed by or in consultation with one of the following specialists:
❑ Dermatologist ❑ Gastroenterologist ❑ Ophthalmologist ❑ Rheumatologist

Will the requested medication be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

For active ankylosing spondylitis (AS), also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to one or more non-steroidal anti-inflammatory drugs (NSAIDs)? ❑ **Yes** ❑ **No**

For active psoriatic arthritis (PsA), also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to methotrexate? ❑ **Yes** ❑ **No**

For moderate to severe plaque psoriasis (PsO), also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to conventional therapy with at least one of the following: phototherapy or one or more oral systemic treatments (i.e., methotrexate, cyclosporine, acitretin, sulfasalazine)? ❑ **Yes** ❑ **No**

For moderate to severe hidradenitis suppurativa, also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to one or more of the following: oral or topical antibiotic therapy OR oral or injectable steroid therapy? ❑ **Yes** ❑ **No**

For moderately to severely active Crohn's disease, also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to one or more immunosuppressive agents (e.g., azathioprine, mercaptopurine, methotrexate)? ❑ **Yes** ❑ **No**

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Humira® Prior Authorization Request Form (Page 2 of 2)

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

For moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA), also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs)? ❑ **Yes** ❑ **No**

For moderately to severely active rheumatoid arthritis (RA), also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs)? ❑ **Yes** ❑ **No**

For moderately to severely active ulcerative colitis, also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to conventional therapy with one or more of the following: corticosteroids (i.e., prednisone, methylprednisolone), 5-ASAs (i.e., mesalamine, sulfasalazine, balsalazide, olsalazine), non-biologic DMARDs (i.e., azathioprine, methotrexate, mercaptopurine)? ❑ **Yes** ❑ **No**

For non-infectious uveitis, also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to one or more of the following: methotrexate, mycophenolate, azathioprine, cyclosporine, tacrolimus, cyclophosphamide? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Patient requires a greater quantity for the treatment of a larger surface area **[Topical applications only]**
- ❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Humira_SouthDakotaMedicaid_2017May-W

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Kineret® Prior Authorization Request Form (Page 1 of 2)

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ Cryopyrin-associated periodic syndromes (CAPS)
❑ Moderately to severely active rheumatoid arthritis (RA)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

For cyropyrin-associated periodic syndromes (CAPS), also answer the following:

Does the patient have a diagnosis of cryopyrin-associated periodic syndromes (CAPS) with neonatal-onset multisystem inflammatory disease (NOMID)? ❑ **Yes** ❑ **No**

Is the requested medication diagnosed by, or upon consultation with or recommendation of, an immunologist, allergist, dermatologist, rheumatologist, neurologist, or other medical specialist? ❑ **Yes** ❑ **No**

For moderately to severely active rheumatoid arthritis (RA), also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs)? ❑ **Yes** ❑ **No**

Will the requested medication be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

Is the requested medication prescribed by or in consultation with a rheumatologist? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Patient requires a greater quantity for the treatment of a larger surface area **[Topical applications only]**
❑ Other: _____

Office use only: Kineret_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Kineret® Prior Authorization Request Form (Page 2 of 2)

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Kineret_SouthDakotaMedicaid_2017May-W

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Orencia® Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA)
❑ Moderately to severely active rheumatoid arthritis (RA)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is the requested medication prescribed by or in consultation with a rheumatologist? ❑ **Yes** ❑ **No**
Will the requested medication be used in combination with another biologic agent? ❑ **Yes** ❑ **No**
Has the patient had an inadequate response, contraindication, or intolerance to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs)? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Patient requires a greater quantity for the treatment of a larger surface area **[Topical applications only]**
❑ Other: _____

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

_____

_____

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_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Orencia_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Otezla® Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Active psoriatic arthritis (PsA)
❑ Moderate to severe chronic plaque psoriasis (PsO)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Select if the requested medication is prescribed by or in consultation with one of the following specialists:
❑ Dermatologist ❑ Rheumatologist

Will the requested medication be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

For active psoriatic arthritis (PsA), also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to methotrexate? ❑ **Yes** ❑ **No**

For moderate to severe plaque psoriasis (PsO), also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to conventional therapy with at least one of the following: phototherapy or one or more oral systemic treatments (i.e., methotrexate, cyclosporine, acitretin, sulfasalazine)? ❑ **Yes** ❑ **No**

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

_____

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Otezla_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Simponi® Prior Authorization Request Form (Page 1 of 2)

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Active ankylosing spondylitis
❑ Active psoriatic arthritis (PsA)
❑ Moderately to severely active rheumatoid arthritis (RA)
❑ Moderately to severely active ulcerative colitis
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Select if the requested medication is prescribed by or in consultation with one of the following specialists:
❑ Dermatologist ❑ Gastroenterologist ❑ Rheumatologist

Will the requested medication be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

For active ankylosing spondylitis (AS), also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to one or more non-steroidal anti-inflammatory drugs (NSAIDs)? ❑ **Yes** ❑ **No**

For active psoriatic arthritis (PsA), also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to methotrexate? ❑ **Yes** ❑ **No**

For moderately to severely active rheumatoid arthritis (RA), also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs)? ❑ **Yes** ❑ **No**

For moderately to severely active ulcerative colitis, also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to conventional therapy with one or more of the following: corticosteroids (i.e., prednisone, methylprednisolone), 5-ASAs (i.e., mesalamine, sulfasalazine, balsalazide, olsalazine), non-biologic DMARDs (i.e., azathioprine, methotrexate, mercaptopurine)? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Patient requires a greater quantity for the treatment of a larger surface area **[Topical applications only]**
❑ Other: _____

Office use only: Simponi_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Simponi® Prior Authorization Request Form (Page 2 of 2)

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

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

_____

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Simponi_SouthDakotaMedicaid_2017May-W

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Stelara® Prior Authorization Request Form (Page 1 of 2)

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Active psoriatic arthritis (PsA)
❑ Moderate to severe chronic plaque psoriasis
❑ Moderately to severely active Crohn's disease
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Select if the requested medication is prescribed by or in consultation with one of the following specialists:
❑ Dermatologist ❑ Gastroenterologist ❑ Rheumatologist

Will the requested medication be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

For active psoriatic arthritis (PsA), also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to methotrexate? ❑ **Yes** ❑ **No**

For moderate to severe plaque psoriasis (PsO), also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to conventional therapy with at least one of the following: phototherapy or one or more oral systemic treatments (i.e., methotrexate, cyclosporine, acitretin, sulfasalazine)? ❑ **Yes** ❑ **No**

For moderately to severely active Crohn's disease, also answer the following:

Has the patient had an inadequate response, contraindication, or intolerance to one or more immunosuppressive agents (e.g., azathioprine, mercaptopurine, methotrexate)? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per TREATMENT? _____ syringe every _____ weeks

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Patient requires a greater quantity for the treatment of a larger surface area **[Topical applications only]**
❑ Other: _____

Office use only: Stelara_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Stelara® Prior Authorization Request Form (Page 2 of 2)

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

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

_____

_____

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_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Stelara_SouthDakotaMedicaid_2017May-W

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Taltz® Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Moderate to severe plaque psoriasis

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is the requested medication prescribed by or in consultation with a dermatologist? ❑ **Yes** ❑ **No**

Will the requested medication be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response, contraindication, or intolerance to conventional therapy with at least one of the following: phototherapy or one or more oral systemic treatments (i.e., methotrexate, cyclosporine, acitretin, sulfasalazine)? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Taltz_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Xeljanz® & Xeljanz XR® Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ Moderately to severely active rheumatoid arthritis

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is the requested medication prescribed by or in consultation with a rheumatologist? ❑ **Yes** ❑ **No**

Will the requested medication be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response, contraindication, or intolerance to methotrexate? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Xeljanz-XeljanzXR_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Topical Ketoconazole Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ Seborrheic dermatitis in immunocompetent patients

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Has the patient had a trial and failure (a minimum of 60 day trial) of ketoconazole cream or shampoo in the past 120 days? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

❑ Patient requires a larger quantity to cover a larger surface area

❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: TopicalKetoconazole_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Topical onychomycosis agents Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Onychomycosis of the toenails

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Has the patient had a trial and failure of 90 days of terbinafine tablets and 90 days of topical ciclopirox in the last 12 months? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: TopicalOnychomycosisAgents_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Luzu® Prior Authorization Request Form

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

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

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

Clinical Information (required)

What is the patient's diagnosis for the medication being requested? (Mandatory)

_____

ICD-10 Code(s) [Mandatory]: _____

Medication history:

Has the patient tried and failed two topical antifungal agents in the last 365 days? ❑ **Yes** ❑ **No**

Has the patient tried and failed two oral antifungal agents in the last 365 days? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Luzu_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Oravig® Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ Local treatment of oropharyngeal candidiasis (OPC)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Has the patient had a trial and failure of clotrimazole troches, fluconazole tablets/suspension, or nystatin suspension within the past 60 days? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Oravig_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Vusion® Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ Adjunctive treatment of diaper dermatitis complicated by candidiasis

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Has the patient had a trial and failure (a minimum of 14 day trial) to topical nystatin or topical OTC miconazole in the last 30 days? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

❑ Patient requires a larger quantity to cover a larger surface area

❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Vusion_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Lidoderm® (lidocaine) Patch Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ Postherpetic neuralgia (PHN)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Lidoderm-lidocainepatch_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Lyrica® Prior Authorization Request Form (Page 1 of 2)

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:
- ❑ Diabetic peripheral neuropathy (DPN)
- ❑ Fibromyalgia
- ❑ Neuropathic pain associated with postherpetic neuralgia (PHN)
- ❑ Neuropathic pain associated with spinal cord injury
- ❑ Partial onset seizure
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Will the patient receive concomitant gabapentin therapy with Lyrica? ❑ **Yes** ❑ **No**

For Lyrica solution requests, also answer the following:

Does the patient have a diagnosis which confirms a difficulty in swallowing? ❑ **Yes** ❑ **No**

Diabetic peripheral neuropathy (DPN), fibromyalgia, and neuropathic pain associated with postherpetic neuralgia (PHN):

Has the patient had a trial and failure, contraindication, or intolerance to a tricyclic antidepressant **AND** an immediate-release gabapentin in the past 180 days? ❑ **Yes** ❑ **No**

Partial onset seizure:

Is Lyrica being used as adjunctive therapy? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?
- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

Office use only: Lyrica_SouthDakotaMedicaid_2017May-P

DSS
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Lyrica® Prior Authorization Request Form (Page 2 of 2)

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

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Lyrica_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Metozolv® ODT (metoclopramide orally disintegrating tablet [ODT]) Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Diabetic gastroparesis (diabetic gastric stasis)
❑ Symptomatic gastroesophageal reflux disease
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Has the patient had a 30-day trial and failure of Brand Reglan or generic metoclopramide tablet or solution within the last 90 days? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: MetozolvODT-metoclopramideODT_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Moxatag® (amoxicillin extended-release [ER]) Prior Authorization Request Form

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

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

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

Clinical Information (required)

Has the patient had a 10-day trial and failure of generic amoxicillin within the past 30 days? ❑ **Yes** ❑ **No**

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

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Moxatag-amoxicillinER_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Multiple Sclerosis Prior Authorization Request Form (Page 1 of 2)

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

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

Medication Information (required)

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

Clinical Information (required)

Select the medication being requested:

❑ Ampyra	❑ Betaseron	❑ Glatopa	❑ Mitoxantrone	❑ Tecfidera
❑ Aubagio	❑ Extavia	❑ Gilenya	❑ Plegridy	❑ Tysabri
❑ Avonex	❑ Copaxone	❑ Lemtrada	❑ Rebif	❑ Zinbryta

Select the diagnosis below:

❑ Moderate-to-severe Crohn's disease (Tysabri only)
❑ Multiple sclerosis
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's specialty:

Select if the requested medication is prescribed by or in consultation with one of the following specialists:
❑ Gastroenterologist (Tysabri only)
❑ Neurologist
❑ Physiatrist (Ampyra only)

For Ampyra, answer the following:

Does the patient have a history of seizures? ❑ **Yes** ❑ **No**

For Aubagio, Avonex, Betaseron, Extavia, Copaxone, Glatopa, Gilenya, Lemtrada, Plegridy, Rebif, Tecfidera, Tysabri, or Zinbryta answer the following:

Does the patient have a relapsing form of multiple sclerosis? ❑ **Yes** ❑ **No**

For mitoxantrone, answer the following:

Select the form of multiple sclerosis that applies to the patient:
❑ Progressive relapsing multiple sclerosis
❑ Secondary progressive multiple sclerosis
❑ Worsening relapsing-remitting multiple sclerosis

Quantity limit requests:

What is the quantity requested per MONTH? _____
What is the reason for exceeding the plan limitations?
❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Patient requires a greater quantity for the treatment of a larger surface area **[Topical applications only]**
❑ Other: _____

Office use only: MultipleSclerosis_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Multiple Sclerosis Prior Authorization Request Form (Page 2 of 2)

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

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Nasal Steroids Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

- ❑ Nonallergic (vasomotor) rhinitis
- ❑ Perennial allergic rhinitis
- ❑ Seasonal allergic rhinitis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Medication history:

Has the patient had a trial and failure of a generic nasal steroid in the past 6 months? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: NasalSteroids_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Nascobal® Prior Authorization Request Form

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

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

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

Clinical Information (required)

Has the patient had a trial and failure of injectable cyanocobalamin within the past 6 months? ❑ **Yes** ❑ **No**

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

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Nascobal_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Nucala® Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ Severe asthma with an eosinophilic phenotype

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Has the patient experienced inadequate control of asthmatic symptoms after a minimum of three months use of a high dose corticosteroid and controller medication? ❑ **Yes** ❑ **No**

Has the patient had at least two asthma exacerbations requiring medical intervention within the past 12 months? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Nucala_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Xolair® Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Asthma
❑ Chronic idiopathic urticaria (CIU)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

For asthma, answer the following:

Does the patient have an elevated serum IgE level? ❑ **Yes** ❑ **No**
Are the patient's symptoms inadequately controlled with inhaled corticosteroids? ❑ **Yes** ❑ **No**
Does the patient have a positive skin test or in vitro reactivity to a perennial aeroallergen? ❑ **Yes** ❑ **No**

For chronic idiopathic urticarial, answer the following:

Does the patient remain symptomatic despite H1 antihistamine treatment? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Patient requires a greater quantity for the treatment of a larger surface area **[Topical applications only]**
❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Xolair_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Nuplazid™ Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ Hallucinations and delusions associated with Parkinson's disease psychosis

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is Nuplazid prescribed by or in consultation with a neurologist or psychiatrist? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Nuplazid_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Nuvessa™ Prior Authorization Request Form

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

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

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

Clinical Information (required)

Has the patient had a trial and failure of metronidazole vaginal gel 0.75% within the past 30 days? ❑ **Yes** ❑ **No**

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

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Nuvessa_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Nuvigil® (armodafinil) and Provigil® (modafinil) Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

- ❑ Excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome
- ❑ Narcolepsy
- ❑ Shift work sleep disorder
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Nuvigil-armodafinil-Provigil-modafinil_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Onfi® Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Intractable treatment-resistant seizure disorder
❑ Seizures associated with Lennox-Gastaut syndrome (LGS)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber specialty:

Is Onfi prescribed by or in consultation with a neurologist? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Onfi_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Bepreve®, Lastacaft®, Pataday®, Patanol® (olopatadine), Pazeo Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Allergic conjunctivitis
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Medication history:

Has the patient had a trial of azelastine, Elestat, Emadine, or ketotifen in the last 120 days? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Topical Acne Agents Prior Authorization Request Form

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

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

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

Clinical Information (required)

Medication history:

Has the patient had a trial and failure of a generic topical acne agent (benzoyl peroxide, tretinoin, clindamycin phosphate, erythromycin, sulfacetamide sodium/sulfur, sulfacetamide sodium) in the last 120 days? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: TopicalAcneAgents_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Oracea® and Solodyn® Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

- ❑ Inflammatory lesions of non-nodular moderate to severe acne vulgaris [**Solodyn** only]
- ❑ Inflammatory lesions (papules and pustules) of rosacea [**Oracea** only]
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Has the patient had a trial and failure (a minimum of 90 day trial) of doxycycline monohydrate, doxycycline hyclate, minocycline IR, or tetracycline in the last180 days? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Orkambi® Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Cystic fibrosis (CF)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Does the patient have a laboratory confirmation of homozygous F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene? ❑ **Yes** ❑ **No**

Was the requested medication prescribed by or in consultation with a pulmonologist or specialist affiliated with a CF care center? ❑ **Yes** ❑ **No**

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

_____

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_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Orkambi_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Otrexup® Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

- ❑ Active polyarticular juvenile idiopathic arthritis (pJIA)
- ❑ Severe, active rheumatoid arthritis (RA)
- ❑ Severe, recalcitrant, disabling psoriasis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

For active polyarticular juvenile idiopathic arthritis (pJIA) or severe, active rheumatoid arthritis (RA), answer the following:

Is the patient intolerant of or has had an inadequate response to first-line therapy? ❑ **Yes** ❑ **No**

Has the patient tried and failed one month of a standard dosage form of methotrexate (e.g., oral, injectable) within the last 180 days? ❑ **Yes** ❑ **No**

For severe, recalcitrant, disabling psoriasis, answer the following:

Has the patient had inadequate response to other forms of therapy? ❑ **Yes** ❑ **No**

Has the patient tried and failed one month of a standard dosage form of methotrexate (e.g., oral, injectable) within the last 180 days? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Otrexup_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Proton Pump Inhibitor Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:
❑ Barrett's esophagitis ❑ Erosive esophagitis ❑ Zollinger-Ellison Syndrome
❑ Other diagnosis: _____ ICD-10 Code(s): _____

For Aciphex sprinkle, First-lansoprazole suspension compounding kit, First omeprazole suspension compounding kit, Nexium pack, omeprazole suspension compounding kit, Prevacid solutab, Protonix pack, and Zegerid pack (omeprazole-sodium bicarbonate pack) requests, answer the following:
Does the patient have a diagnosis that confirms a difficulty in swallowing? ❑ **Yes** ❑ **No**

For Aciphex tablet, Dexilant, esomeprazole strontium capsule, Nexium capsule (esomeprazole magnesium capsule), Prevacid capsule, Prevpack (lansoprazole-amoxicillin-clarithromycin), Prilosec capsule, Protonix tablet, and Zegerid capsule (omeprazole-sodium bicarbonate capsule) requests, answer the following:
Has the patient had a trial and failure (after a minimum of 14 days) in the past year with at least one of the following generics: Lansoprazole, omeprazole, pantoprazole, or rabeprazole? ❑ **Yes** ❑ **No**

Has the patient experienced an adverse reaction (must be documented on a MedWatch form), allergy or contraindication to **ALL** of the following: Lansoprazole, omeprazole, pantoprazole, and rabeprazole? ❑ **Yes** ❑ **No**

Quantity limit requests:
What is the quantity requested per DAY? _____
What is the reason for exceeding the plan limitations?
❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: ProtonPumpInhibitors_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Duexis® & Vimovo® Prior Authorization Request Form (Page 1 of 2)

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Ankylosing spondylitis [**Vimovo** only]
❑ Osteoarthritis
❑ Rheumatoid arthritis
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Does the patient have a history of peptic ulcer disease/gastrointestinal (GI) bleed? ❑ **Yes** ❑ **No**

Does the patient have one additional risk factor for gastrointestinal adverse events (e.g., use of anticoagulants, chronic corticosteroids)? ❑ **Yes** ❑ **No**

Does the patient have a history of asthma or urticaria after taking aspirin or other NSAIDs? ❑ **Yes** ❑ **No**

For Duexis requests, please also answer the following:

Has the patient had a 30 day trial of a preferred generic H2-receptor blocker (e.g., famotidine, cimetidine, ranitidine, nizatidine) AND a generic NSAID within the last 180 days? ❑ **Yes** ❑ **No**

For Vimovo requests, please also answer the following:

Has the patient had a 30 day trial of a preferred generic proton pump inhibitor (e.g., omeprazole, lansoprazole, pantoprazole) AND a generic NSAID within the last 180 days? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

DSS
Strong Families - South Dakota's Foundation and Our Future

Duexis® & Vimovo® Prior Authorization Request Form (Page 2 of 2)

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

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

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Qualaquin® (quinine) Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Malaria

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Qualaquin-quinine_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Rayos® Prior Authorization Request Form

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

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

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

Clinical Information (required)

Has the patient had a trial and failure of generic prednisone tablets in the past 60 days? ❑ **Yes** ❑ **No**

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

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Rayos_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Relistor® Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ Opioid-induced constipation in adult patients with advanced illness

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Does the patient require palliative care? ❑ **Yes** ❑ **No**

Has the patient had at least a 10 day trial and failure of one other laxative (e.g., stimulant, osmotic, bulk forming, etc.) in the last 30 days? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Relistor_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Soma® 250 (carisoprodol) Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Acute painful musculoskeletal condition

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Medication history:

Has the patient had a 6 month trial of carisoprodol 350 mg within the last 120 days? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other: _____

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

_____

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_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Soma250-carisoprodol250_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Tivorbex™ Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Has the patient had a trial and failure (a minimum of a combined 30 day trial) of two generic prescription strength nonsteroidal anti-inflammatory drugs (NSAIDs) in the past 180 days? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Tivorbex_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Ultram® ER (tramadol extended-release [ER]) Prior Authorization Request Form

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

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

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

Clinical Information (required)

Clinical information:

Is the patient currently stable on tramadol ER tablet or Ultram ER? ❑ **Yes** ❑ **No**

Has the patient failed a 30 day trial of immediate release tramadol in the last 120 days? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: UltramER-tramadolER_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Conzip®, Synapryn®, tramadol extended-release (ER) biphasic capsule, tramadol ER biphasic tablet Prior Authorization Request Form

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

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

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

Clinical Information (required)

Clinical information:

Is the patient currently stable on Conzip, Synapryn (tramadol suspension), tramadol ER biphasic capsule, or tramadol ER biphasic tablet? ❑ **Yes** ❑ **No**

Has the patient failed a 30-day trial of generic immediate-release tramadol in the last 120 days? ❑ **Yes** ❑ **No**

Has the patient had an adverse reaction to generic immediate-release tramadol and the prescriber has documented it on a MedWatch form? ❑ **Yes** ❑ **No**

Has the patient had a drug allergy or contraindication to generic immediate-release tramadol and the prescriber has documented it in the patient's chart notes/medical records? ❑ **Yes** ❑ **No**

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

_____

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Triptans Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Migraine with or without aura

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Medication history:

Has the patient had a trial and failure of a generic triptan within the last 6 months? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Triptans_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Maxalt-MLT® (rizatriptan orally disintegrating tabet [ODT]) & Zomig ZMT® (zolmitriptan ODT) Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Migraine with or without aura

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Does the patient have a diagnosis which confirms a difficulty in swallowing? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Onzetra™ Xsail™ Prior Authorization Request Form

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

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

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

Clinical Information (required)

Has the patient had a trial and failure to at least six other triptans in the past 36 months? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: OnzetraXsail_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Uloric Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ Chronic gout

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Has the patient received an adequate trial of at least 1 month of allopurinol? ❑ **Yes** ❑ **No**

Does the patient have renal or hepatic dysfunction? ❑ **Yes** ❑ **No**

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

_____

_____

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_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Viberzi™ Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Irritable bowel syndrome with diarrhea (IBS-D)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

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

_____

_____

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_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Viberzi_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Xifaxan® Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

- ❑ Hepatic encephalopathy (HE)
- ❑ Irritable bowel syndrome with diarrhea (IBS-D)
- ❑ Travelers' diarrhea
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

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

_____

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_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Xifaxan_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Xenazine® Prior Authorization Request Form

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

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

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

Clinical Information (required)

Clinical information:

Does the patient have a confirmed diagnosis of chorea associated with Huntington's disease? ❑ **Yes** ❑ **No**

Is the requested medication prescribed by or in consultation with a neurologist or psychiatrist? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Xenazine_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Xyrem® Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Narcolepsy with cataplexy
❑ Narcolepsy with excessive daytime sleepiness
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is the patient enrolled in the Xyrem Success Program? ❑ **Yes** ❑ **No**

For narcolepsy with excessive daytime sleepiness, answer the following:

Has the patient had a previous trial of at least one of the following standard stimulant agents: amphetamine/dextroamphetamine, armodafinil, modafinil, dextroamphetamine, methylphenidate? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Patient requires a greater quantity for the treatment of a larger surface area **[Topical applications only]**
❑ Other: _____

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

_____

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Xyrem_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Ambien CR® (zolpidem extended-release [ER]), Edluar™, Intermezzo® (zolpidem sublingual tablet [SL]), Zolpimist™ Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ Insomnia

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Medication history:

Has the patient had a trial (at least a 14 day trial in the last 365 days) and inadequate response, adverse reaction (prescriber must have documented it on a MedWatch form), or contraindication to generic immediate release oral zolpidem tablets or brand Ambien tablets? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other: _____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: AmbienCR-zolpidemER-Edluar-Intermezzo-zolpidemSL-Zolpimist_SouthDakotaMedicaid_2017May-P

DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-800-527-0531
Mon-Sat: 7am to 7pm Central

Praluent® & Repatha® Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

- ❑ Heterozygous familial hypercholesterolemia (HeFH)
- ❑ Homozygous familial hypercholesterolemia (HoFH) [**Repatha** only]
- ❑ Hyperlipidemia in a high risk patient with clinical arteriosclerotic cardiovascular disease (ASCVD)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is the patient's baseline LDL-C level greater than or equal to 160 mg/dL? ❑ **Yes** ❑ **No**

Has the patient been receiving high dose statin therapy for at least 3 months (i.e., atorvastatin tab 40 mg, atorvastatin tab 80 mg, rosuvastatin tab 20 mg, rosuvastatin tab 40 mg)? ❑ **Yes** ❑ **No**

Is the patient a non-candidate for high dose statin therapy (e.g., labeled contraindication to all statins, patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with creatine kinase elevations greater than 10 times upper limit of normal [ULN])? ❑ **Yes** ❑ **No**

Is the requested medication prescribed by or in consultation with a cardiologist or endocrinologist? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Opioid cough suppressants in children – FDA Advisory Committee Recommendations

- On September 11, 2017, the FDA held a Pediatric Advisory Committee Meeting to discuss the benefit/risk of prescription codeine and hydrocodone antitussives in pediatric patients.

- Opioids can cause respiratory depression, and children are particularly vulnerable. Labels on products containing opioids warn about this risk in children. Other risks include misuse, abuse, addiction, overdose, and death.

- FDA advisory committee votes:

    - The committee voted (21 no, 2 yes, 1 abstain) that the benefit/risk profile is not favorable for use of prescription opioid cough suppressants for treatment of cough in pediatric patients.
    - The committee voted unanimously (24 no, 0 yes) that the benefit/risk profile is not favorable for use of prescription codeine cough suppressants for treatment of cough associated with allergy or the common cold in pediatric patients aged 12 to < 18 years of age.
    - The committee voted by a majority that the benefit/risk profile is not favorable for use of hydrocodone cough suppressants for treatment of cough associated with allergy or the common cold in pediatric patients aged 6 to < 12 years (23 no, 1 yes) or in pediatric patients aged 12 to < 18 years (23 no, 1 yes).

- Examples of codeine-containing cough syrups include promethazine/codeine, promethazine/phenylephrine/codeine, and M-End® PE, Poly-Tussin® AC (brompheniramine/phenylephrine/codeine).

- Examples of hydrocodone-containing cough syrups include Rezira® (pseudoephedrine/hydrocodone), Zutripro® (chlorpheniramine/pseudoephedrine/hydrocodone), and chlorpheniramine/hydrocodone.

- A FDA expert roundtable meeting was held on April 27, 2017 to discuss the use of cough suppressants in children < 18 years of age. This meeting provided background information and framed the questions for the FDA Pediatric Advisory Committee.

- Codeine-containing cough suppressants contain a boxed warning for respiratory depression in children, death related to ultra-rapid metabolism of codeine to morphine and risks from concomitant use with benzodiazepines or other central nervous system (CNS) depressants.

- Hydrocodone-containing cough suppressants contain a boxed warning for risks from concomitant use with benzodiazepines or other CNS depressants.

- A prior FDA Drug Safety Communication regarding use of codeine in children can be found at https://www.fda.gov/downloads/Drugs/DrugSafety/UCM553814.pdf

    - The FDA announced that new updates will be made to the *Contraindications* and *Warnings* sections of all prescription codeine and tramadol drug products regarding their use in children, adolescents and breastfeeding women.

Opioid Cough and Cold Utilization

Date frame: 1/1/2017 to 2/12/2018
Members less than 18 years old for GPI 43 utilization

GPI 43: COUGH/COLD/ALLERGY		Number of Claims	Paid Amount	Unique # of Patients	Age Group
Mucolytics	Acetylcysteine Inhalation Solution 20%	20	$1,713.11	5	1-11 years
Respiratory Inhalants	NaCl Solution Nebulizer 0.9%, 3%, 7%	724	$10,134.78	554	0-17 years
Decongestant & Antihistamine	Cetirizine-D	104	$2,980.57	52	9-17 years
Decongestant & Antihistamine	Fexofenadine-D	11	$419.67	1	16 years
Decongestant & Antihistamine	Loratadine-D	180	$2,600.46	103	5-17 years
Decongestant & Antihistamine	Promethazine & Phenylephrine Syrup 6.25-5 mg/5ml	1	$9.99	1	9 years
Decongestant & Antihistamine	Brompheniramine & Phenylephrine Elixir 1-2.5mg/5ml	3	$23.31	1	11 years
Antitussives	Benzonatate Capsule 100mg	310	$2,622.04	282	5-17 years
Antitussives	Benzonatate Capsule 200mg	102	$1,191.09	98	9-17 years
Non-Narc Antitussive-Decong-Antihistamine	Pseudoephed-Brompheniramine-DM Syrup 30-2-10 mg/5ml	357	$8,722.91	241	0-17 years
Expectorants	Guaifenesin Liquid 100mg/5ml	1	$5.98	1	4 years
Antitussive-Expectorant	Dextromethorphan-Guaifenesin Syrup 10-100 mg/5ml	1	$5.60	1	14 years
Antitussive-Expectorant	**Guaifenesin-Codeine Solution 100-10mg/5ml**	**474**	**$6,499.38**	**444**	**0-17 years**
Opioid Antitussive-Antihistamine	**Hydrocodone-Chlorpheniramine ER Suspension 10-8 mg/5ml**	**5**	**$283.27**	**5**	**12-17 years**
Opioid Antitussive Antihistamine	**Promethazine w/Codeine Syrup 6.25-10 mg/5ml**	**213**	**$1,595.68**	**193**	**2-17 years**
Non-Narc Antitussive-Antihistamine	Promethazine-DM Syrup 6.25-15 mg/5ml	29	$183.80	25	6-17 years
Total		**2,535**	**$38,911.64**	**1,913***	

*Not the sum for unique number of patients

Antitussive-Expectorant:	Age Breakdown	Unique # of Patients	Number of Claims	Quantity Dispensed	Paid Amount	Avg Paid/ Rx
Guaifenesin-Codeine Solution 100-10mg/5ml	2 months	1	1	120 ml	$10.81	$10.81
	2 years	5	5	50 to 180 ml	$62.12	$12.41
	3 years	4	4	60 to 180 ml	$41.68	$10.42
	4 years	16	16	60 to 180 ml	$182.42	$11.40
	5 years	21	23	10 to 240 ml	$271.27	$11.79
	6 years	31	36	10 to 240 ml	$463.33	$12.87
	7 years	21	21	30 to 240 ml	$282.18	$13.44
	8 years	21	26	15 to 240 ml	$337.34	$12.97
	9 years	40	41	60 to 473 ml	$570.22	$13.91
	10 years	29	31	20 to 240 ml	$396.38	$12.79
	11 years	28	31	50 to 360 ml	$469.97	$15.16
	12 years	38	42	50 to 240 ml	$527.06	$12.55
	13 years	27	28	20 to 240 ml	$389.30	$13.90
	14 years	33	37	30 to 473 ml	$571.46	$15.44
	15 years	38	38	15 to 240 ml	$501.83	$13.21
	16 years	44	45	50 to 240 ml	$661.29	$14.70
	17 years	47	49	118 to 360 ml	$760.72	$15.52
Total		**444**	**474**		**$6,499.38**	

Opioid Antitussive-Antihistamine:	Age Breakdown	Unique # of Patients	Number of Claims	Quantity Dispensed	Paid Amount	Avg Paid/ Rx
Hydrocodone-Chlorpheniramine ER Suspension 10-8 mg/5ml	12 years	1	1	50 ml	$31.41	$31.41
	15 years	1	1	115 ml	$60.79	$60.79
	16 years	2	2	115 ml	$126.39	$63.20
	17 years	1	1	115 ml	$64.68	$64.68
Total		**5**	**5**		**$283.27**	

Opioid Antitussive Antihistamine:	Age Breakdown	Unique # of Patients	Number of Claims	Quantity Dispensed	Paid Amount	Avg Paid/ Rx
Promethazine w/Codeine Syrup 6.25-10 mg/5ml	2 years	3	3	60 to 240 ml	$19.03	$6.34
	4 years	1	2	240 to 300 ml	$17.59	$8.80
	5 years	3	4	100 to 120 ml	$24.57	$6.14
	6 years	4	4	118 to 180 ml	$25.69	$6.42
	7 years	9	9	60 to 300 ml	$66.63	$7.40
	8 years	6	6	120 to 180 ml	$44.03	$7.34
	9 years	9	11	120 to 300 ml	$84.23	$7.66
	10 years	18	20	120 to 240 ml	$141.34	$7.07
	11 years	16	16	120 to 360 ml	$115.39	$7.21
	12 years	13	13	60 to 240 ml	$88.45	$6.80
	13 years	23	27	60 to 240 ml	$192.91	$7.14
	14 years	22	23	50 to 240 ml	$184.54	$8.02
	15 years	21	25	90 to 240 ml	$193.54	$7.74
	16 years	21	25	100 to 240 ml	$182.58	$7.30
	17 years	24	25	50 to 473 ml	$215.16	$8.61
Total		**193**	**213**		**$1,595.68**	

PRODUCT DETAILS OF INGREZZA® (valbenazine)

Neurocrine Biosciences

INDICATIONS AND USE

A vesicular monoamine transporter 2 (VMAT2) inhibitor indicated for the treatment of adults with tardive dyskinesia.

- Tardive dyskinesia (TD) is an iatrogenic condition that results from the long-term use of dopamine receptor blocking agents, predominantly antipsychotics/neuroleptics and metoclopramide.

DOSAGE AND ADMINISTRATION

Initial dose of 40 mg once daily. After 1 week, increase the dose to the recommended dose of 80 mg once daily. Continuation of 40 mg once may be considered for some patients or those with moderate to severe hepatic failure.

DOSAGE FORMS AND STRENGTHS

Capsule: 40 mg and 80 mg

CONTRAINDICATIONS

None

WARNINGS AND PRECAUTIONS

- Somnolence
- QT prolongation
- Should be avoided in patients with congenital QT syndrome or with arrhythmias associated with a prolonged QT interval

ADVERSE REACTIONS

- Somnolence (10%)
- Anticholinergic effects (5%)
- Balance disorders/falls (4%)
- Headache (3%)
- Akathisia (2%)
- Vomiting (2%)
- Nausea (2%)
- Arthralgia (2%)

DRUG INTERACTIONS

- Concomitant use of monamine oxidase inhibitors (MAOI) is not recommended, as this could result in increased synaptic levels of monoamine oxidase, which can lead to serotonin syndrome. *Examples: isocarboxazid, phenelzine, selegiline*

- Concomitant use of strong Cytochrome P450 (CYP) 3A4 inducers is also not recommended, as this could lead to decreased levels of valbenazine. *Examples: rifampin, carbamazepine, phenytoin, St. John's wort*
- Valbenazine dose may need to be decreased when given concomitantly with strong CYP3A4 and CYP2D6 inhibitors. *Examples: CYP3A4 Inhibitors – itraconazole, ketoconazole, clarithromycin; CYP2D5 Inhibitors – paroxetine, fluoxetine, quinidine*

USE IN SPECIAL POPULATIONS

- Pregnancy: May cause fetal harm
- Lactation: Advise not to breastfeed
- Renal Impairment: No dosage adjustment is necessary for patients with mild to moderate renal impairment. Use is not recommended in patients with severe renal impairment.

OVERVIEW OF TD TREATMENT AGENTS

- Tetrabenazine (Xenazine), a VMAT2 inhibitor FDA-approved for Huntington's chorea, used off-label to treat TD
- Deutetrabenazine (Austedo), a VMAT2 inhibitor indicated for the treatment of chorea associated with Huntington's disease; and treatment of tardive dyskinesia in adults

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INTRODUCTION

- Tardive dyskinesia (TD) is an iatrogenic condition that results from the long-term use of dopamine receptor blocking agents (DRBAs), predominantly antipsychotics/neuroleptics (first generation antipsychotics [FGAs], also known as typical antipsychotics, as well as second-generation antipsychotics [SGAs], which are also known as atypical antipsychotics) and metoclopramide *(Rana et al 2013).*
- While the pathophysiology of TD is not well-understood, the most prominent theory suggests chronic exposure to neuroleptics results in dopamine-2 (D2) receptor up-regulation with postsynaptic dopamine receptor supersensitivity *(Waln and Jankovic 2013).*
- Prospective studies of patients treated with FGAs suggest that the annual incidence of TD is between 3 to 8%. With SGAs, the mean annual incidence is estimated at 2.1 to 4.2%. Although TD prevalence has been less studied with metoclopramide, the published data indicate a prevalence ranging from 1 to 10% (*Waln and Jankovic 2013).*
- The lower incidence of TD with SGAs compared to FGAs is hypothesized to be a result of pharmacologic differences in dopamine and serotonin receptor affinity. SGAs tend to have lower D2 receptor occupancy and higher serotonin receptor activity than FGAs *(Howland et al 2011, Vijayakumar and Jankovic 2016).*
- TD is characterized by rapid, repetitive, stereotypic movements mostly involving the oral, buccal, and lingual area (Muller et al 2015). Movements may include tongue thrusting, lip smacking or pursing, grimacing and chewing movements, piano-playing finger movements, trunk and pelvic thrusting, flexion/extension of the ankles or toes, irregular respirations, and various vocalizations (*Rana et al 2013*).
- TD can affect the ability of patients to perform activities of daily living as well as make it more difficult for them to engage in the community or workplace, given the visibility of involuntary movements and societal stigma related to mental illness *(FDA Ingrezza Medical Review*).
- According to the Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV), TD develops during exposure to a DRBA for ≥ 3 months (or one month in patients ≥ 60 years of age) or within four weeks of withdrawal from an oral medication (or within eight weeks of withdrawal from a depot medication). The disorder should persist for at least one month after discontinuation of an offending drug to qualify as TD (*Waln and Jankovic 2013*).
- The first step in the treatment of TD is to discontinue the offending agent via slow taper. Sudden withdrawal of the offending drug should be avoided, as symptoms of TD could worsen. In patients with psychiatric conditions which require continued use of a neuroleptic, switching from an FGA to an SGA could be considered. Quetiapine and clozapine are the preferred SGAs due to their low receptor occupancy and fast dissociation from D2 receptors (*Vijayakumar and Jankovic 2016*).
- Ingrezza (valbenazine), a vesicular monoamine transporter 2 (VMAT2) inhibitor approved by the Food and Drug Administration (FDA) on April 11, 2017, was granted fast track status, priority review, and breakthrough therapy designation *(FDA Web site).*
  - Valbenazine is the first and only drug approved by the FDA for TD.
  - The mechanism of action of valbenazine is thought to be mediated through the reversible inhibition of VMAT2, a transporter that regulates monoamine uptake from the cytoplasm to the synaptic vesicle for storage and release. In other words, by modulating the pre-synaptic packaging and release of dopamine into the synapse, striatal dopamine depletion can be achieved (*Hauser et al 2017, Jankovic 2016*).
  - Valbenazine is the third VMAT2 inhibitor approved by the FDA; Xenazine (tetrabenazine) and Austedo (deutetrabenazine) were the first VMAT2 inhibitors approved in August 2008 and April 3, 2017, respectively. Both are indicated in the treatment of Huntington's chorea (*Austedo product information 2017, Xenazine product information 2015*).
  - Unlike tetrabenazine and deutetrabenazine, valbenazine does not carry a boxed warning for increased risk of depression and suicidal thoughts or behavior (*Austedo product information 2017, Xenazine product information 2015).*
  - Valbenazine is currently being studied as a potential treatment for Tourette's syndrome (phase 2) *(Ingrezza Web site).*
- Medispan class: Psychotherapeutic and Neurological Agents – Misc.; Movement Disorder.

INDICATION

- Valbenazine is indicated for the treatment of adults with TD *(Ingrezza prescribing information 2017*).

Information on indications, mechanism of action, pharmacokinetics, dosing, and safety has been obtained from the prescribing information for the individual products, except where noted otherwise

CLINICAL EFFICACY SUMMARY

- The FDA approval of valbenazine was based on the results from the KINECT 3 trial, a 6-week, phase 3, double-blind, placebo-controlled, multicenter, randomized clinical trial with 224 patients with moderate to severe TD *(Hauser et al 2017, FDA Ingrezza Medical Review).*
  - In this trial, 66.1% of patients had schizophrenia or schizoaffective disorder, while 33.9% had a mood disorder. Additionally, 85.5% received concomitant antipsychotics (16.7% on FGAs and 76.7% on SGAs).
  - The mean baseline Abnormal Involuntary Movement Scale (AIMS) dyskinesia score was 10.0 (range 0 to 20) between the treatment groups.
  - Patients were randomized 1:1:1 to receive valbenazine 40 mg once daily, valbenazine 80 mg once daily, or placebo.
  - The primary endpoint was the AIMS dyskinesia score, which was a modified version of the AIMS score. The AIMS dyskinesia score included 7 items rating involuntary movements in the orofacial region, extremities, and trunk on a scale from 0 (no dyskinesia) to 4 (severe dyskinesia). The original AIMS consists of a 12-item rating scale that includes the 7 aforementioned items as well as three items rating global severity, patients awareness, and distress associated with movements, and 2 items concerning problems with teeth and dentures. AIMS has been validated and widely used to assess the presence and severity of TD.
    - The AIMS dyskinesia score was evaluated by remote central video raters (movement specialists) via recordings for each patient visit. These raters were blinded to the patient's identity, visit number, and treatment arm.
    - The AIMS dyskinesia score was reduced from baseline to six weeks by 3.2 in the valbenazine 80 mg group compared to 0.1 in the placebo group ($p < 0.001$). In the valbenazine 40 mg group, the AIMS dyskinesia score decreased by 1.9 compared to 0.1 in the placebo group ($p = 0.002$).
  - The percentage of patients who achieved an AIMS response (defined in the trial as a reduction of ≥ 50% from baseline score) was 40.0% in the 80 mg group ($p < 0.001$) and 23.8% in the 40 mg group ($p = 0.02$), compared to 8.7% in the placebo group.
  - The key secondary endpoint of mean Clinical Global Impression of Change - Tardive Dyskinesia (CGI-TD) score was used by site investigators to rate the overall change in TD from baseline at Week 6. CGI-TD scores ranged from 1 (very much improved) to 7 (very much worse). The mean CGI-TD score did not reach statistical significance for either valbenazine dosage group when compared to placebo ($p = 0.056$ and $p = 0.074$ for valbenazine 80 mg and 40 mg, respectively).
  - Another secondary endpoint was Patient Global Impression of Change (PGIC), which characterized the patient's perception of improvement in their TD symptoms. The mean PGIC score at Week 6 was slightly worse in both valbenazine treatment groups compared to placebo, but the differences did not reach nominal statistical significance.
  - With the exploratory endpoint of improvement in tardive dyskinesia impact scale (TDIS) score, both doses of valbenazine were numerically superior to placebo at Weeks 4 and 6, however, the differences did not reach statistical significance.
  - The most common adverse effects (AE) observed with valbenazine (both dosage groups combined) vs. placebo were somnolence (5.3% vs. 3.9%), akathisia (3.3% vs. 1.3%), and dry mouth (3.3% vs. 1.3%). Suicidal ideation was the most common AE in the placebo group (5.3% vs. 2.6% in both valbenazine groups combined).
  - The results from the long-term extension study (KINECT 3 Extension) were presented in the form of a poster at the 55th Annual Meeting of the American College of Neuropsychopharmacology in December 2016 *(Grigoriadis et al 2016)*.
    - Subjects who completed the 6-week trial were eligible to participate in the 42-week extension period (with a 4-week washout period at the end of the 48-week period). Those initially randomized to placebo were re-randomized 1:1 to valbenazine 80 or 40 mg/day; those initially randomized to valbenazine 80 or 40 mg/day continued at the same dose.
    - The primary and secondary endpoints (ie, AIMS dyskinesia score change from baseline to Week 48 and CGI-TD score at Week 48, respectively) remained the same in the extension period.
    - At Week 48, mean changes from baseline (of the six week trial) were -4.8 and -3.0for valbenazine 80 and 40 mg/day, respectively (p-value not provided).
    - At Week 48, 52.4% and 28.3% of patients on valbenazine 80 mg/day and 40 mg/day, respectively, were AIMS 50% responders (p-value not provided).

- CGI-TD scores demonstrated clinically meaningful global improvement for both treatment groups (p-value not provided).
- The PGIC and TDIS scores showed improvement in patient perception from Week 8 to Week 48 in both valbenazine groups, however, the FDA stated that the patient's awareness of their treatment with active drug and attrition bias could have confounded these results.
- After the 4-week treatment washout period (at week 52), TD severity began reverting towards baseline levels, and responder rates were lower than those observed at week 8.

CLINICAL GUIDELINE

- **American Academy of Neurology (AAN)** Evidence-based guideline: Treatment of tardive syndromes (TS) *(Bhidayasiri et al 2013)*
  - Level A recommendations (recommendation must be done; high confidence in the evidence with high benefit and low risk)
    - None
  - Level B recommendations (recommendation should be done based on benefit/risk profile)
    - Ginkgo biloba extract (EGb-761) for schizophrenia only
    - Clonazepam, for short-term use
  - Level C recommendations (recommendation may or might be done; lowest recommendation level considered useful within the scope of practice)
    - Amantadine for short-term use
    - Tetrabenazine
  - Level U (available evidence is insufficient to support or refute efficacy of an intervention)
    - Withdrawal of DRBAs
    - Switching from typical to atypical antipsychotics
    - Acetazolamide plus thiamine
    - Typical antipsychotics
    - Atypical antipsychotics
    - Electroconvulsive therapy
    - Reserpine or α-methyldopa
    - Bromocriptine
    - Anticholinergic agents (other than galantamine)
    - Biperiden discontinuation
    - Antioxidants (vitamin E, vitamin B6, melatonin, selegiline, yi-gan san)
    - Baclofen
    - Levetiracetam
    - Nifedipine
    - Buspirone
    - Botulinum toxin
    - Pallidal deep-brain stimulation

SAFETY SUMMARY

- **Contraindications**
  - None

- **Warnings/precautions**
  - Somnolence
  - QT prolongation
    - Valbenazine should be avoided in patients with congenital long QT syndrome or with arrhythmias associated with a prolonged QT interval.

- **Adverse effects**

Table 1. AEs reported in ≥ 2% of patients

AE	Valbenazine (n = 262)	Placebo (n = 183)

Somnolence (somnolence, fatigue, sedation)	10.9%	4.2%
Anticholinergic effects (dry mouth, constipation, disturbance in attention blurred vision, urinary retention)	5.4%	4.9%
Balance disorders/falls (fall gait disturbance, dizziness, balance disorder)	4.1%	2.2%
Headache	3.4%	2.7%
Akathisia	2.7%	0.5%
Vomiting	2.6%	0.6%
Nausea	2.3%	2.1%
Arthralgia	2.3%	0.5%

- **Drug Interactions**
  - Concomitant use of monamine oxidase inhibitors (MAOI) is not recommended, as this could result in increased synaptic levels of monoamine oxidase, which can lead to serotonin syndrome.
  - Concomitant use with strong Cytochrome P450 (CYP) 3A4 inducers is also not recommended, as this could lead to decreased levels of valbenazine.
  - Valbenazine dose may need to be decreased when given concomitantly with strong CYP3A4 and CYP2D6 inhibitors.

DOSING AND ADMINISTRATION

Table 2. Dosing and Administration

Drug	Available Formulations	Route	Usual Recommended Frequency	Comments
Ingrezza (valbenazine)	Capsules	Oral	Daily	A lower dose should be administered in patients with moderate to severe hepatic failure

See the current prescribing information for full details

CONCLUSION

- The approval of valbenazine has provided the first FDA-approved treatment option for TD.
  - Valbenazine was granted priority review, accelerated approval, breakthrough therapy designation by the FDA.
- Prior to the approval of valbenazine, tetrabenazine, a VMAT2 inhibitor FDA-approved for Huntington's chorea, was used off-label to treat TD.
- The first step in the treatment of TD is to discontinue the offending agent by slow taper. The patient can switch to quetiapine and clozapine (SGAs of choice) if needed.
- The KINECT 3 trial demonstrated a significant reduction in AIMS dyskinesia score at -3.2 in the valbenazine 80 mg/day group and -1.9 in the valbenazine 40 mg/day group, however, there were no significant improvements in the CGI-TD score or patient-perceived improvement in function or QOL.
- The extension trial continued to demonstrate reductions in AIMS dyskinesia score at week 48, from baseline in both dosage groups.
- The 2013 American Academy of Neurology (AAN) evidence-based guidelines for the treatment of tardive syndromes (TS) did not make any level A (highest level of evidence for efficacy) treatment recommendations. Gingko biloba and clonazepam were recommended in the level B category, amantadine and tetrabenazine were recommended in the level C category, and a large number of other agents/therapies were recommended in the level U (insufficient evidence) category.

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Publication Date: September 8, 2017

PRODUCT DETAILS OF XEPI™ (ozenoxasin)

Medimetriks Pharmaceuticals

INDICATIONS AND USE

Topical non-fluorinated quinolone indicated for the topical treatment of impetigo due to *Staphlococcus aureus* or *Streptococcus pyogenes* in adult and pediatric patients 2 months of age or older.

DOSAGE AND ADMINISTRATION

Apply a thin layer topically to the affected area twice daily for 5 days.

DOSAGE FORMS AND STRENGTH

Cream: 1%, each gram contains 10 mg of ozenoxacin

CONTRAINDICATIONS

None

WARNINGS AND PRECAUTIONS

Prolonged use may result in overgrowth of nonsusceptible bacterial and fungi.

ADVERSE REACTIONS

Rosacea and seborrheic dermatitis reported in one adult patient.

DRUG INTERACTIONS

There are no known significant interactions

Launch date 1Q18

OVERVIEW OF IMPETIGO TREATMENT AGENTS

Mupirocin ointment
Oral antibiotics

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