South Dakota Department of Social Services

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Tirosint®capsule/levothyroxine capsule 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)

Enter diagnosis below:
Diagnosis: _____ ICD-10 Code(s): _____

New to Tirosint capsule or levothyroxine capsule therapy:
Has the patient tried 2 different levothyroxine tablets in the last 180 days? ❑ Yes ❑ No
Has the patient experienced failure to levothyorixine tablets? ❑ Yes ❑ No If yes, explain_____

_____

Submit documentation of medication failure.
Does the patient have an allergy, contraindication, drug-to-drug interaction, or history of unacceptablet/toxic side effects with levothyroxine tablets? ❑ Yes ❑ No If yes, explain_____

_____

Submit documentation of allergy, contraindication, drug-to-drug interaction, or history of unacceptable/toxic side effects with levothyroxine tablets.

Patient is currently taking Tirosint capsule/levothyroxine capsule therapy:
Has the patient tried 2 different levothyroxine tablets? ❑ Yes ❑ No If yes, explain _____
Submit documentation of trial and failure.

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 1-844-403-1029.

Office use only: Tirosint_SouthDakotaMedicaid_2023July