South Dakota
Department of Social Services

Medicaid P&T Committee Meeting

December 13, 2019

DSS

Strong Families - South Dakota's Foundation and Our Future

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DEPARTMENT OF SOCIAL SERVICES
OFFICE OF THE SECRETARY
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291
PHONE: 605-773-3165
FAX: 605-773-4855
WEB: dss.sd.gov

Strong Families - South Dakota's Foundation and Our Future

SOUTH DAKOTA
MEDICAID P&T COMMITTEE MEETING
AGENDA

December 13, 2019
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 previous meeting minutes

PA update

Review of top 15 therapeutic categories/top 50 drugs

Old business
- **CGRP utilization**
- **Orilissa utilization**
- **Opioid update**

New business
- **Review PA forms & criteria**
- **Lyrica PA**
- **Head Lice PA**
- **Topical Acne PA**
- **Ophthalmic Antihistamines PA**
- **Sunosi**
- **Apadaz**

Public comment accepted after individual topic discussion
Next meeting date 3/13/2019 & adjournment

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

Friday, September 27, 2019
1:00 – 3:00 pm CT

Members and DSS Staff

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

Administrative Business
Darger called the meeting to order at 1:08 PM. The minutes of the June meeting were presented. Ladwig 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 from April 1, 2019 to June 30, 2019. A total of 1,991 PAs were reviewed of which 333 requests (16.73%) were received via telephone and 1,133 requests (56.91%) were received via fax, and 525 (26.37%) were reviewed via electronically. The Committee also reviewed the PA Approval Reviews with 96% to 82% approvals. Van Gilder questioned the daptomycin and insulin quantity limit reviews.

Analysis of the Top 15 Therapeutic Classes and Drug Spend
The Committee reviewed the top 15 therapeutic classes by total cost of claims from April 1, 2019 to June 30, 2019. The top five therapeutic classes based on paid amount were atypical antipsychotics, anticonvulsants, disease-modifying anti-rheumatic agents, amphetamines, and respiratory and CNS stimulants. The top 15 therapeutic classes make up 24.06% 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 6.85% of total claims.

Old Business
Committee reviewed CGRP utilization comparing 1Q19 vs 2Q19. Utilization increased slightly. There were no utilization for Orlissa during 2Q19. Committee requested to review utilization for both classes again at the next meeting.

Committee reviewed ADHD/ADD utilization for 2Q19 for members 26 years and older. Committee requested to review this class when a committee member with psychiatry background is available. Committee inquired how other Medicaid states are managing this class. Ladwig requested the MME level of the 18 recipients taking ADD/ADHD medication with concomitant utilization with opioid/benzodiazepine/antipsychotic.

Committee reviewed opioid outcomes from the opioid initiatives. Utilization level and MME levels indicate a decreased trend.

New Business
The Committee reviewed utilization for albuterol inhalers and deliberated on quantity limits for this class. Committee requested utilization for patients routinely using two or more inhalers per month. Utilization to include prescriber and concomitant maintenance medication usage.

The Committee reviewed buprenorphine utilization to potentially loosen buprenorphine criteria in consequence of opioid utilization management initiatives. Initially, PA implemented on buprenorphine was due to potential misuse for pain management instead of using it for opioid withdrawal. After discussion, Ladwig made a motion to remove PA on buprenorphine. Engelbrecht seconded the motion. Motion was approved unanimously.

In support of the Federal Support Act, concomitant opioid utilization with benzodiazepine and opioid utilization with antipsychotics were provided to the Committee for review. Jockheck confirmed South Dakota Medicaid met minimum requirements with message only currently in place for opioids/benzodiazepine. After discussion, Ladwig made a motion to set soft edits for opioids/benzodiazepine and opioid/antipsychotic. Holm seconded the motion. Motion was approved unanimously.

The Committee reviewed the recommendation from the Ad Hoc Committee on Pain Management and Prescription Drug Abuse, titled "Effective management of Acute Pain" by the South Dakota State Medical Association. Jockheck reminded Committee on the current opioid edits for opioid naive and on long acting and short acting opioids. Engelbrecht and Darger commented since opioid management strategies are already in place for South Dakota Medicaid, if Committee members wanted to recommend additional opioid initiatives, to provide them at future meetings.

The Committee reviewed the tetracycline therapy class, especially new drugs Seysara and Nuzyra. There was no public testimony provided. After drug and utilization review, Committee recommended adding step therapy to Seysara to the current Oracea/Solodyn step therapy. Ladwig made a motion to add Seysara to step therapy and Holm seconded the motion. Motion was approved unanimously.

The Committee reviewed the multiple sclerosis (MS) therapy class, especially new drugs Mayzent and Mavenclad. There was no public testimony provided. After drug and utilization review, Petrik made a motion to add Mayzent and Mavenclad to the current MS PA criteria with neurology consult. Ladwig seconded the motion. Motion was approved unanimously.

Snyder provided an update regarding the Committee's recommendation from the June meeting. DSS continues to evaluate the recommendation.

The next meeting is scheduled for December 13, 2019. Tentative meeting dates for next year are March 13, 2020 and June 5, 2020. Ladwig made a motion to adjourn the meeting and Holm seconded the motion. The motion passed unanimously and the meeting adjourned at 3:22 PM.

PA Report
7/1/2019 to 9/30/2019

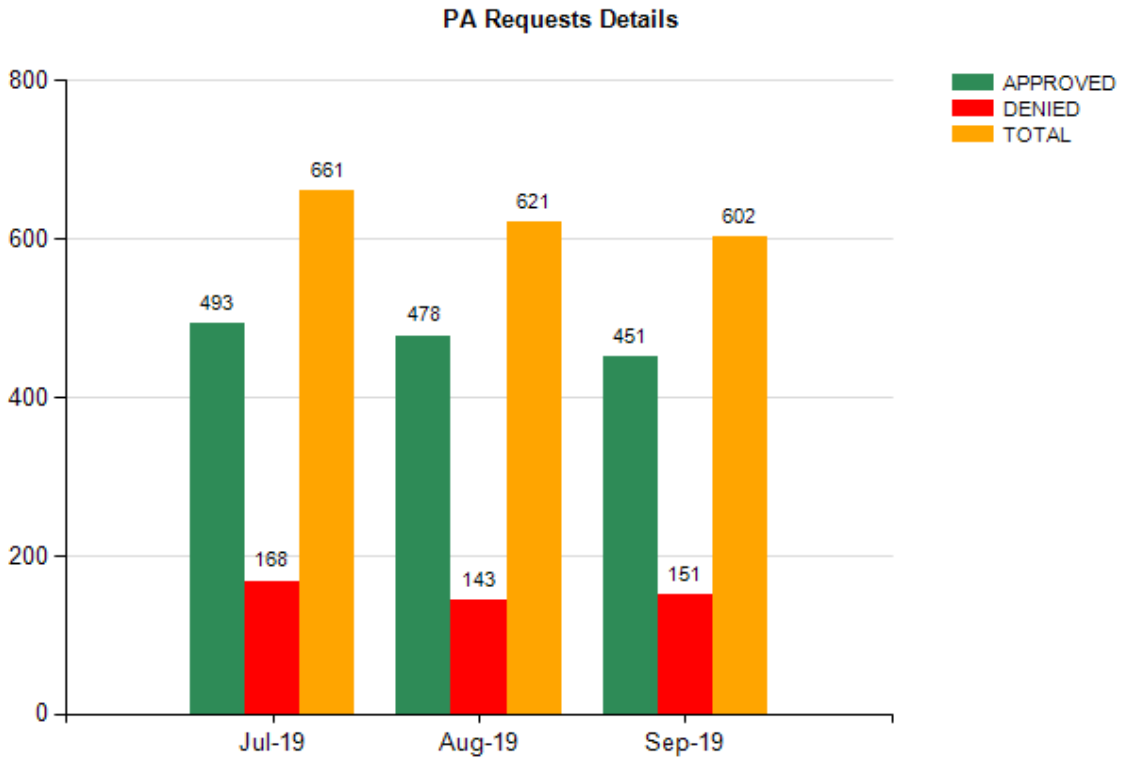
Compliance Summary

Priority	Total PAs	PAs Compliant (Standard - 72 Hrs Urgent - 24 Hrs)	PAs Not Compliant	% PAs Compliant	% PAs Not Compliant
STANDARD	1,830	1,830	0	100%	0%
URGENT	54	54	0	100%	0%
GRAND TOTAL	**1,884**	**1,884**	**0**		

	# of	Phone Requests		Fax Requests		Real-Time PA	
Drug Class	Requests	#	%	#	%	#	%
TOTAL	1,884	296	15.71%	1,063	56.42%	525	27.87%

PA Initial Requests Summary

Month	Approved	Denied	Total
Jul-19	493	168	661
Aug-19	478	143	621
Sep-19	451	151	602
3Q19	1,422	462	1,884
Percent of Total	75.48%	24.52%	



Top 5 Therapeutic Classes for PA

Drug Class	Approved	Denied	Total	Approval Rate	% of Total Requests	Most Requested Products
65 - ANALGESICS-OPIOID*	212	75	287	73.87%	15.23%	TRAMADOL, HYDROCODONE/APAP
59 - ANTIPSYCHOTICS/ ANTIMANIC AGENTS*	227	22	249	91.16%	13.22%	, ARIPIPRAZOLE
58 - ANTIDEPRESSANTS*	178	28	206	86.41%	10.93%	, FLUOXETINE HCL
90 - DERMATOLOGICALS*	110	87	197	55.84%	10.46%	SKLICE, LIDOCAINE
49 – ULCER DRUGS/ ANTISPASMODICS/ANTICHOLINEG	133	31	164	81.10%	8.70%	, ESOMEPRAZOLE MAGNESIUM
Others -	562	219	781	71.96%	41.45%	
3Q19	1422	462	1884	75.48%		

PA Drug Class Summary

Drug Class	Approved	Denied	Total	Approval Rate
59 - ANTIPSYCHOTICS/ANTIMANIC AGENTS*	227	22	249	91.16%
65 - ANALGESICS - OPIOID*	212	75	287	73.87%
58 - ANTIDEPRESSANTS*	178	28	206	86.41%
49 - ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERG	133	31	164	81.10%
90 - DERMATOLOGICALS*	110	87	197	55.84%
83 - ANTICOAGULANTS*	79	5	84	94.05%
72 - ANTICONVULSANTS*	65	52	117	55.56%
27 - ANTIDIABETICS*	60	3	63	95.24%
52 - GASTROINTESTINAL AGENTS - MISC.*	51	12	63	80.95%
41 - ANTIHISTAMINES*	38	5	43	88.37%
61 - ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREX	36	11	47	76.60%
54 - URINARY ANTISPASMODICS	33	9	42	78.57%
66 - ANALGESICS - ANTI-INFLAMMATORY*	30	11	41	73.17%
16 - ANTI-INFECTIVE AGENTS - MISC.*	27	0	27	100.00%
62 - PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENT	25	1	26	96.15%
67 - MIGRAINE PRODUCTS*	19	28	47	40.43%
30 - ENDOCRINE AND METABOLIC AGENTS - MISC.*	14	7	21	66.67%
50 - ANTIEMETICS*	11	8	19	57.89%
44 - ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	10	1	11	90.91%
12 - ANTIVIRALS*	8	13	21	38.10%
21 - ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	8	0	8	100.00%
40 - CARDIOVASCULAR AGENTS - MISC.*	6	3	9	66.67%
75 - MUSCULOSKELETAL THERAPY AGENTS*	6	3	9	66.67%
34 - CALCIUM CHANNEL BLOCKERS*	5	0	5	100.00%
60 - HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENT	5	3	8	62.50%
86 - OPHTHALMIC AGENTS*	5	36	41	12.20%
39 - ANTIHYPERLIPIDEMICS*	4	1	5	80.00%
36 - ANTIHYPERTENSIVES*	3	0	3	100.00%
19 - PASSIVE IMMUNIZING AND TREATMENT AGENTS*	2	0	2	100.00%
45 - RESPIRATORY AGENTS - MISC.*	2	1	3	66.67%
68 - GOUT AGENTS*	2	0	2	100.00%
00 - COMPOUND & MISCELLANEOUS	1	0	1	100.00%
04 - TETRACYCLINES*	1	0	1	100.00%
05 - FLUOROQUINOLONES*	1	0	1	100.00%
11 - ANTIFUNGALS*	1	1	2	50.00%
32 - ANTIANGINAL AGENTS*	1	0	1	100.00%
33 - BETA BLOCKERS*	1	0	1	100.00%
38 - VASOPRESSORS*	1	0	1	100.00%
94 - DIAGNOSTIC PRODUCTS*	1	1	2	50.00%
01 - PENICILLINS*	0	1	1	0.00%
02 - CEPHALOSPORINS*	0	1	1	0.00%
42 - NASAL AGENTS - SYSTEMIC AND TOPICAL*	0	2	2	0.00%
3Q19	**1422**	**462**	**1884**	
Percent of Total	**75.48%**	**24.52%**		

PA Appeals Summary

Month	Approved	Approved %	Denied	Denied %	Total
Jul-19	17	80.95%	4	19.05%	21
Aug-19	13	81.25%	3	18.75%	16
Sep-19	9	69.23%	4	30.77%	13
3Q19	39	78.00%	11	22.00%	50

Appeals Detail

Drug Class	Approved	Denied	Total	Approval Rate
LYRICA	6	1	7	85.71%
PREGABALIN	3	0	3	100.00%
HYDROCODONE/APAP	2	0	2	100.00%
NEXIUM	2	0	2	100.00%
OXYCODONE HCL	2	0	2	100.00%
TRAMADOL HCL	2	0	2	100.00%
ADDERALL XR	1	0	1	100.00%
AJOVY	1	0	1	100.00%
AMITIZA	1	1	2	50.00%
ARIPIPRAZOLE	1	0	1	100.00%
CABERGOLINE	1	0	1	100.00%
DULOXETINE HYDROCHLORIDE	1	0	1	100.00%
EMGALITY	1	1	2	50.00%
ENOXAPARIN SODIUM	1	0	1	100.00%
FENTANYL	1	0	1	100.00%
HUMIRA	1	0	1	100.00%
INVEGA SUSTENNA	1	0	1	100.00%
JUBLIA	1	0	1	100.00%
LANSOPRAZOLE	1	0	1	100.00%
MALATHION	1	0	1	100.00%
MODAFINIL	1	0	1	100.00%
NORDITROPIN FLEXPRO	1	0	1	100.00%
NOXAFIL	1	0	1	100.00%
PULMOZYME	1	0	1	100.00%
SOFOSBUVIR/VELPATASVIR	1	0	1	100.00%
TRINTELLIX	1	0	1	100.00%
VIGABATRIN	1	0	1	100.00%
XARELTO	1	0	1	100.00%
CLOBAZAM	0	1	1	0.00%
DOXYLAMINE SUCCINATE/PYRIDOXINE HCL	0	1	1	0.00%
MAVYRET	0	5	5	0.00%
OLOPATADINE HYDROCHLORIDE	0	1	1	0.00%
3Q19	39	11	50	

Top 15 Therapeutic Classes & Top 50 Drugs

TOP 15 THERAPEUTIC CLASSES BASED ON NUMBER OF CLAIMS FROM 7/1/2019 – 9/30/2019				
AHFS Description	**Total Rxs**	**Pharmacy Due Amount**	**Paid/Rx**	**%Total Claims**
SELECTIVE-SEROTONIN REUPTAKE INHIBITORS	11,812	$152,194.88	$12.88	6.02%
MISCELLANEOUS ANTICONVULS	10,530	$1,109,213.12	$105.34	5.37%
SECOND GENERATION ANTIHIS	8,124	$95,192.75	$11.72	4.14%
ATYPICAL ANTIPSYCHOTICS	7,761	$1,930,389.15	$248.73	3.95%
SELECTIVE BETA-2-ADRENERGIC AGONISTS	6,975	$502,380.22	$72.03	3.55%
RESPIRATORY AND CNS STIMULANTS	6,268	$866,106.20	$138.18	3.19%
OPIATE AGONISTS	6,229	$214,736.59	$34.47	3.17%
AMPHETAMINES	6,006	$1,037,830.40	$172.80	3.06%
PROTON-PUMP INHIBITORS	5,715	$198,451.02	$34.72	2.91%
AMINOPENICILLIN ANTIBIOTICS	5,564	$79,942.22	$14.37	2.83%
ADRENALS	5,329	$586,363.66	$110.03	2.72%
THYROID AGENTS	3,738	$71,677.53	$19.18	1.90%
LEUKOTRIENE MODIFIERS	3,495	$50,131.04	$14.34	1.78%
HMG-COA REDUCTASE INHIBIT	3,313	$40,917.58	$12.35	1.69%
MISC. CENTRAL NERVOUS SYS	3,308	$167,961.40	$50.77	1.69%
Total Top 15 Therapeutic Classes	**94,167**	**$7,103,487.76**	**$75.44**	**47.98%**

TOP 15 THERAPEUTIC CLASSES BASED ON AMOUNT PAID FROM 7/1/2019 – 9/30/2019				
AHFS Description	**Total Rxs**	**Pharmacy Due Amount**	**Paid/Rx**	**%Total Claims**
ATYPICAL ANTIPSYCHOTICS	7,761	$1,930,389.15	$248.73	3.95%
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	243	$1,143,969.69	$4,707.69	0.12%
MISCELLANEOUS ANTICONVULS	10,530	$1,109,213.12	$105.34	5.37%
AMPHETAMINES	6,006	$1,037,830.40	$172.80	3.06%
RESPIRATORY AND CNS STIMULANTS	6,268	$866,106.20	$138.18	3.19%
ANTINEOPLASTIC AGENTS	315	$728,402.65	$2,312.39	0.16%
RAPID-ACTING INSULINS	1,277	$627,742.66	$491.58	0.65%
LONG-ACTING INSULINS	1,432	$598,399.64	$417.88	0.73%
SKIN AND MUCOUS MEMBRANE	421	$596,500.95	$1,416.87	0.21%
ADRENALS	5,329	$586,363.66	$110.03	2.72%
SELECTIVE BETA-2-ADRENERGIC AGONISTS	6,975	$502,380.22	$72.03	3.55%
HEMOSTATICS	48	$459,414.06	$9,571.13	0.02%
CYSTIC FIBROSIS (CFTR) CORRECTORS	21	$407,174.59	$19,389.27	0.01%
COMPOUND	1,574	$308,695.86	$196.12	0.80%
INCRETIN MIMETICS	416	$300,061.31	$721.30	0.21%
Total Top 15 Therapeutic Classes	**48,616**	**$11,202,644.16**	**$230.43**	**24.77%**

Total Rx Claims from 7/1/2019 – 9/30/2019	**196,266**

TOP 50 DRUGS BASED ON NUMBER OF CLAIMS FROM 7/1/2019 – 9/30/2019					
AHFS Description	**Drug Label Name**	**Total Rxs**	**Pharmacy Due Amount**	**Paid/Rx**	**%Total Claims**
SECOND GENERATION ANTIHISTAMINES	CETIRIZINE TAB 10MG	3,332	$32,308.55	$9.70	1.70%
SELECTIVE BETA-2-ADRENERGIC AGONISTS	ALBUTEROL AER HFA	3,168	$146,132.16	$46.13	1.61%
AMINOPENICILLIN ANTIBIOTICS	AMOXICILLIN SUS 400/5ML	2,529	$32,140.42	$12.71	1.29%
PROTON-PUMP INHIBITORS	OMEPRAZOLE CAP 20MG	2,469	$27,563.48	$11.16	1.26%
SECOND GENERATION ANTIHIS	LORATADINE TAB 10MG	2,063	$23,785.42	$11.53	1.05%
SELECTIVE-SEROTONIN REUPTAKE INHIBITORS	FLUOXETINE CAP 20MG	2,021	$17,223.32	$8.52	1.03%
SEROTONIN MODULATORS	TRAZODONE TAB 50MG	1,876	$16,898.36	$9.01	0.96%
CORTICOSTEROIDS	FLUTICASONE SPR 50MCG	1,805	$28,864.69	$15.99	0.92%
SELECTIVE-SEROTONIN REUPTAKE INHIBITORS	SERTRALINE TAB 100MG	1,729	$20,345.17	$11.77	0.88%
OPIATE AGONISTS	HYDROCO/APAP TAB 5-325MG	1,691	$21,017.16	$12.43	0.86%
MISCELLANEOUS ANTICONVULS	GABAPENTIN CAP 300MG	1,562	$24,240.35	$15.52	0.80%
COMPOUND	COMPOUND	1,528	$86,535.14	$56.63	0.78%
CENTRAL ALPHA-AGONISTS	CLONIDINE TAB 0.1MG	1,514	$14,996.48	$9.91	0.77%
LEUKOTRIENE MODIFIERS	MONTELUKAST TAB 10MG	1,468	$17,145.76	$11.68	0.75%
SELECTIVE-SEROTONIN REUPTAKE INHIBITORS	SERTRALINE TAB 50MG	1,426	$16,216.62	$11.37	0.73%
LEUKOTRIENE MODIFIERS	MONTELUKAST CHW 5MG	1,380	$18,630.80	$13.50	0.70%
OPIATE AGONISTS	TRAMADOL HCL TAB 50MG	1,292	$13,994.62	$10.83	0.66%
RESPIRATORY AND CNS STIMULANTS	METHYLPHENID TAB 36MG ER	1,246	$221,821.82	$178.03	0.63%
SELECTIVE BETA-2-ADRENERGIC AGONISTS	ALBUTEROL NEB 0.083%	1,186	$18,277.80	$15.41	0.60%
ANTIBACTERIALS (SKIN & MU	MUPIROCIN OIN 2%	1,183	$17,952.31	$15.18	0.60%
SECOND GENERATION ANTIHIS	CETIRIZINE SOL 1MG/ML	1,159	$14,754.99	$12.73	0.59%
PROTON-PUMP INHIBITORS	OMEPRAZOLE CAP 40MG	1,140	$13,274.63	$11.64	0.58%
VITAMIN D	VITAMIN D CAP 50000 UNT	1,045	$10,515.15	$10.06	0.53%
CENTRALLY ACTING SKELETAL MUSCLE RELAX	CYCLOBENZAPR TAB 10MG	1,018	$9,349.03	$9.18	0.52%
5-HT3 RECEPTOR ANTAGONIST	ONDANSETRON TAB 4MG ODT	966	$14,460.03	$14.97	0.49%
SELECTIVE-SEROTONIN REUPTAKE INHIBITORS	ESCITALOPRAM TAB 10MG	930	$10,120.67	$10.88	0.47%
SELECTIVE-SEROTONIN REUPTAKE INHIBITORS	ESCITALOPRAM TAB 20MG	928	$10,279.82	$11.08	0.47%
1ST GENERATION CEPHALOSPORINS	CEPHALEXIN CAP 500MG	915	$10,285.55	$11.24	0.47%
SELECTIVE-SEROTONIN REUPTAKE INHIBITORS	FLUOXETINE CAP 40MG	904	$8,332.85	$9.22	0.46%
SELECTIVE-SEROTONIN REUPTAKE INHIBITORS	FLUOXETINE CAP 10MG	892	$8,421.78	$9.44	0.45%
ADRENALS	PREDNISOLONE SOL	890	$12,136.14	$13.64	0.45%
BIGUANIDES	METFORMIN TAB 500MG	879	$7,525.58	$8.56	0.45%
AMINOPENICILLIN ANTIBIOTICS	AMOXICILLIN CAP 500MG	875	$9,634.67	$11.01	0.45%
SEROTONIN MODULATORS	TRAZODONE TAB 100MG	867	$9,278.92	$10.70	0.44%
ADRENALS	PREDNISONE TAB 20MG	839	$7,708.73	$9.19	0.43%
OTHER NONSTEROIDAL ANTI-INFLAM	IBUPROFEN TAB 800MG	829	$10,392.97	$12.54	0.42%
SEL.SEROTONIN,NOREPI REUPTAKE INHIBIT	DULOXETINE CAP 60MG	812	$12,148.35	$14.96	0.41%
OTHER MACROLIDE ANTIBIOTICS	AZITHROMYCIN TAB 250MG	812	$10,980.59	$13.52	0.41%
RESPIRATORY AND CNS STIMULANTS	METHYLPHENID TAB 54MG ER	804	$137,325.84	$170.80	0.41%
MISC. CENTRAL NERVOUS SYS	GUANFACINE TAB 2MG ER	791	$16,983.20	$21.47	0.40%
HISTAMINE H2-ANTAGONISTS	RANITIDINE TAB 150MG	769	$8,130.87	$10.57	0.39%
BENZODIAZEPINES (ANTICONVULSANT)	CLONAZEPAM TAB 0.5MG	759	$7,874.51	$10.37	0.39%
1ST GENERATION CEPHALOSPORINS	CEPHALEXIN SUS 250/5ML	747	$20,802.24	$27.85	0.38%
BENZODIAZEPINES (ANTICONVULSANT)	CLONAZEPAM TAB 1MG	742	$8,054.26	$10.85	0.38%
OTHER NONSTEROIDAL ANTI-INFLAM.	MELOXICAM TAB 15MG	730	$5,670.15	$7.77	0.37%
PROTON-PUMP INHIBITORS	PANTOPRAZOLE TAB 40MG	721	$8,702.65	$12.07	0.37%
ANTIDEPRESSANTS, MISCELLANEOUS	BUPROPN HCL TAB 150MG XL	721	$12,551.22	$17.41	0.37%
AMPHETAMINES	VYVANSE CAP 30MG	719	$194,480.02	$270.49	0.37%
CORTICOSTEROIDS (SKIN, MUCOUS MEM)	TRIAMCINOLON CRE 0.1%	719	$9,926.33	$13.81	0.37%
VITAMIN B COMPLEX	FOLIC ACID TAB 1MG	713	$6,328.36	$8.88	0.36%
TOTAL TOP 50 DRUGS		**62,103**	**$1,444,520.53**	**$23.23**	**31.64%**

TOP 50 DRUGS BASED ON AMOUNT PAID FROM 7/1/2019 – 9/30/2019					
AHFS Description	**Drug Label Name**	**Total Rxs**	**Pharmacy Due Amount**	**Paid/Rx**	**%Total Claims**
RAPID-ACTING INSULINS	NOVOLOG INJ FLEXPEN	565	$304,418.96	$538.79	0.29%
ATYPICAL ANTIPSYCHOTICS	INVEGA SUST INJ 234/1.5	107	$276,493.73	$2,584.05	0.05%
DISEASE-MODIFYING ANTIRHEUMATIC	HUMIRA PEN INJ 40MG/0.8	41	$257,501.56	$6,280.53	0.02%
RESPIRATORY AND CNS STIMULANTS	METHYLPHENID TAB 36MG ER	1,246	$221,821.82	$178.03	0.63%
LONG-ACTING INSULINS	LANTUS SOLOS INJ 100/ML	584	$204,992.23	$351.01	0.30%
MUCOLYTIC AGENTS	PULMOZYME SOL 1MG/ML	50	$198,214.14	$3,964.28	0.03%
AMPHETAMINES	VYVANSE CAP 30MG	719	$194,480.02	$270.49	0.37%
DISEASE-MODIFYING ANTIRHEUMATIC	HUMIRA PEN INJ 40/0.4ML	28	$186,715.69	$6,668.42	0.01%
AMPHETAMINES	VYVANSE CAP 40MG	619	$169,567.90	$273.94	0.32%
CYSTIC FIBROSIS (CFTR) CORRECTORS	ORKAMBI GRA 150-188	8	$167,437.84	$20,929.73	0.00%
CYSTIC FIBROSIS (CFTR) POTENTIATORS	KALYDECO TAB 150MG	7	$167,336.51	$23,905.22	0.00%
ATYPICAL ANTIPSYCHOTICS	ARISTADA INJ 882MG/3	64	$159,686.74	$2,495.11	0.03%
SKIN AND MUCOUS MEMBRANE	COSENTYX PEN INJ 300DOSE	21	$155,730.55	$7,415.74	0.01%
DISEASE-MODIFYING ANTIRHEUMATIC	ENBREL SRCLK INJ 50MG/ML	30	$152,728.77	$5,090.96	0.02%
AMPHETAMINES	VYVANSE CAP 50MG	564	$151,274.27	$268.22	0.29%
SKIN AND MUCOUS MEMBRANE	STELARA INJ 90MG/ML	7	$149,379.26	$21,339.89	0.00%
SELECTIVE BETA-2-ADRENERGIC AGONISTS	ALBUTEROL AER HFA	3,168	$146,132.16	$46.13	1.61%
LONG-ACTING INSULINS	LEVEMIR INJ FLEXTOUC	298	$137,572.20	$461.65	0.15%
RESPIRATORY AND CNS STIMULANTS	METHYLPHENID TAB 54MG ER	804	$137,325.84	$170.80	0.41%
CYSTIC FIBROSIS (CFTR) CORRECTORS	SYMDEKO TAB 100-150	8	$135,088.10	$16,886.01	0.00%
ANTINEOPLASTIC AGENTS	AFINITOR DIS TAB 2MG	5	$134,524.56	$26,904.91	0.00%
-	INGREZZA CAP 80MG	21	$132,456.40	$6,307.45	0.01%
AMPHETAMINES	VYVANSE CAP 20MG	460	$130,785.61	$284.32	0.23%
ADRENALS	FLOVENT HFA AER 110MCG	541	$130,342.52	$240.93	0.28%
ATYPICAL ANTIPSYCHOTICS	LATUDA TAB 80MG	115	$127,783.92	$1,111.16	0.06%
ATYPICAL ANTIPSYCHOTICS	INVEGA SUST INJ 156MG/ML	73	$126,215.77	$1,728.98	0.04%
ATYPICAL ANTIPSYCHOTICS	LATUDA TAB 40MG	129	$125,756.89	$974.86	0.07%
HEMOSTATICS	ADVATE INJ 1500UNIT	4	$122,136.72	$30,534.18	0.00%
DISEASE-MODIFYING ANTIRHEUMATIC	XELJANZ XR TAB 11MG	28	$122,097.22	$4,360.62	0.01%
HCV POLYMERASE INHIBITOR ANTIVIRALS	EPCLUSA TAB 400-100	5	$121,553.55	$24,310.71	0.00%
RIFAMYCIN ANTIBIOTICS	XIFAXAN TAB 550MG	61	$108,455.33	$1,777.96	0.03%
MISCELLANEOUS ANTICONVULS	EPIDIOLEX SOL 100MG/ML	55	$108,128.99	$1,965.98	0.03%
HIV INTEGRASE INHIBITORS	GENVOYA TAB	36	$107,838.72	$2,995.52	0.02%
RAPID-ACTING INSULINS	NOVOLOG INJ 100/ML	227	$102,596.12	$451.97	0.12%
ATYPICAL ANTIPSYCHOTICS	ABILIFY MAIN INJ 400MG	45	$98,341.99	$2,185.38	0.02%
DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS	JANUVIA TAB 100MG	231	$96,518.07	$417.83	0.12%
SOMATOTROPIN AGONISTS	NORDITROPIN INJ 10/1.5ML	28	$94,799.86	$3,385.71	0.01%
RESPIRATORY TRACT AGENTS, MISC	XOLAIR SOL 150MG	27	$94,010.27	$3,481.86	0.01%
INCRETIN MIMETICS	VICTOZA INJ 18MG/3ML	122	$91,600.48	$750.82	0.06%
HIV INTEGRASE INHIBITORS	BIKTARVY TAB	32	$90,138.30	$2,816.82	0.02%
RAPID-ACTING INSULINS	NOVOLOG INJ PENFILL	232	$89,755.82	$386.88	0.12%
AMPHETAMINES	VYVANSE CAP 70MG	337	$88,776.41	$263.43	0.17%
HEMOSTATICS	RECOMBINATE INJ 801-1240	4	$86,620.80	$21,655.20	0.00%
COMPOUND	COMPOUND	1,528	$86,535.14	$56.63	0.78%
DISEASE-MODIFYING ANTIRHEUMATIC	HUMIRA INJ 40/0.4ML	13	$86,470.93	$6,651.61	0.01%
RESPIRATORY AND CNS STIMULANTS	METHYLPHENID TAB 18MG ER	537	$84,372.18	$157.12	0.27%
RESPIRATORY AND CNS STIMULANTS	METHYLPHENID TAB 27MG ER	639	$84,116.90	$131.64	0.33%
CYSTIC FIBROSIS (CFTR) CORRECTORS	ORKAMBI GRA 100-125	4	$83,718.92	$20,929.73	0.00%
ATYPICAL ANTIPSYCHOTICS	ARISTADA INJ 1064MG	28	$83,224.90	$2,972.32	0.01%
ATYPICAL ANTIPSYCHOTICS	LATUDA TAB 20MG	77	$83,165.33	$1,080.07	0.04%
TOTAL TOP 50 DRUGS		**14,582**	**$6,796,736.91**	**$466.10**	**7.43%**

Utilization

Time frame: 7/1/2019 – 9/30/2019
Red font denotes drug is on Prior Authorization

CGRP Inhibitors

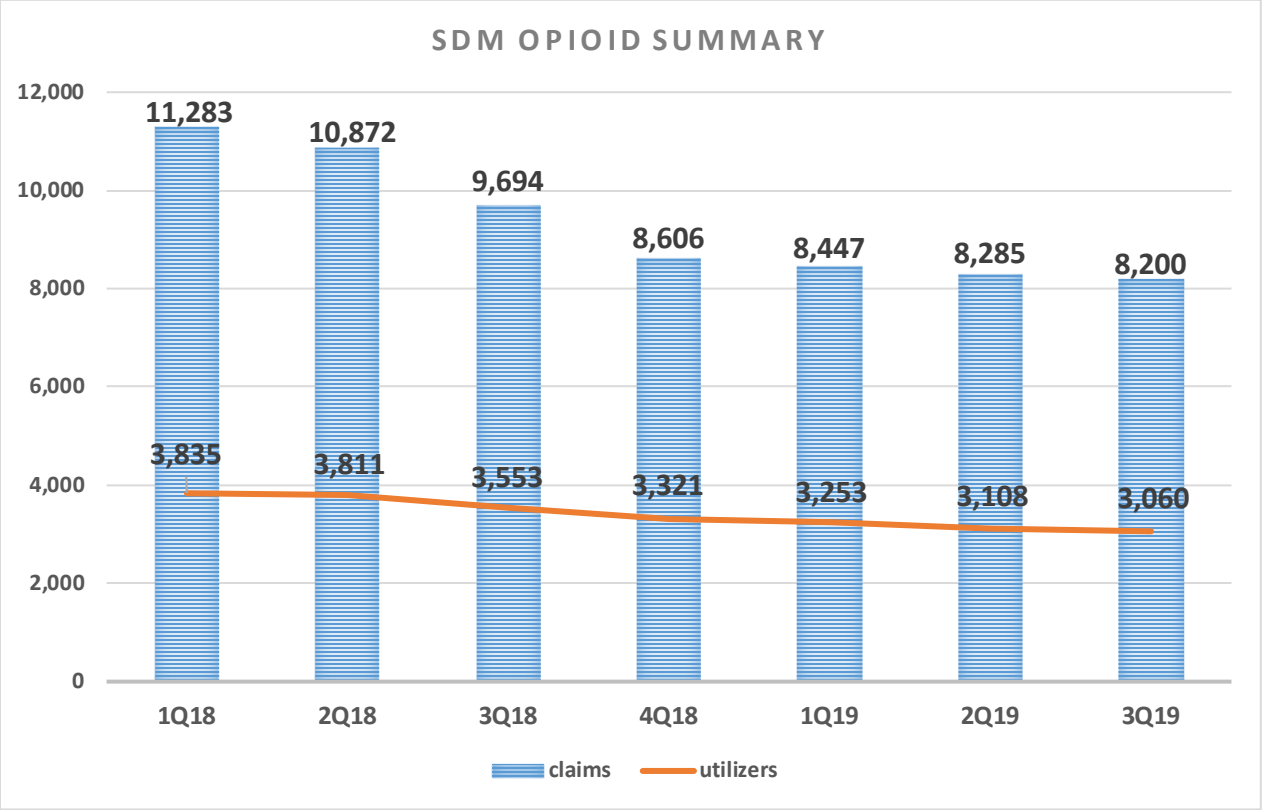
	2Q 2019				3Q 2019			
Drug Name	**Total Rx**	**Paid Amount**	**Paid/Rx**	**Utilizing Members**	**Total Rx**	**Paid Amount**	**Paid/Rx**	**Utilizing Members**
Aimovig	53	$30,139.63	$568.67	22	49	$27,560.62	$562.46	21
Ajovy	4	$2,248.20	$562.05	2	7	$3,934.35	$562.05	3
Emgality	10	$7,288.66	$728.87	6	26	$16,251.92	$625.07	10

Orilissa

	1Q 2019				3Q 2019			
Drug Name	**Total Rx**	**Paid Amount**	**Paid/Rx**	**Utilizing Members**	**Total Rx**	**Paid Amount**	**Paid/Rx**	**Utilizing Members**
Orilissa	3	$2,511.49	$837.16	2	4	$3,312.86	$828.22	3

*Some states are watching utilization; other states added to PA
**2Q19 utilization = 0

Opioid Update



Opioid Utilization Snapshot

SDM 2Q2019

Mar 19 to Jun 19

Opioid Claims **8,285**

3.9% prescription claims filled for an opioid

0.4% lower than Med D benchmark

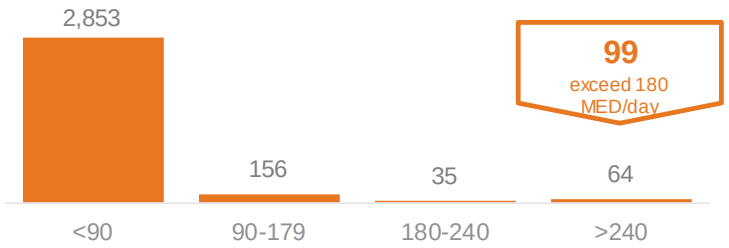
Utilizers **3,108**

34.8% are high utilizers [1]

15.2% lower than high utilizers Med D benchmark

Utilizers by Cumulative MED[4]

Current CDC Guidelines[5] urge doses of 90 MME[6] or less in chronic opioid utilizers[5]



Shoppers: Poly Pharmacy

54 opioid utilizing members with 3+ pharmacies

Shoppers: Poly Prescriber

140 Shoppers: Poly Prescriber

opioid utilizing members with 3+ prescribers

3Q2019

Jun 19 to Sep 19

Opioid Claims **8,200**

4.0% prescription claims filled for an opioid

0.3% lower than Med D benchmark

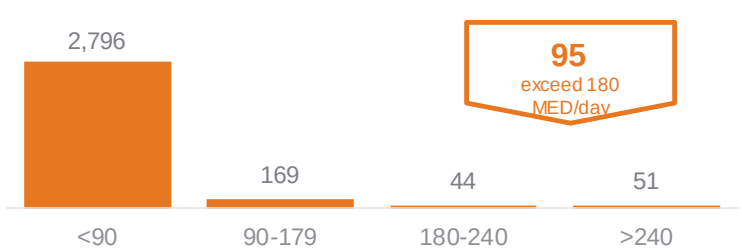
Utilizers **3,060**

36.0% are high utilizers [1]

9.1% lower than high utilizers Med D benchmark

Utilizers by Cumulative MED[4]

Current CDC Guidelines[5] urge doses of 90 MME[6] or less in chronic opioid utilizers[5]



Shoppers: Poly Pharmacy

48 opioid utilizing members with 3+ pharmacies

Shoppers: Poly Prescriber

193 Shoppers: Poly Prescriber

opioid utilizing members with 3+ prescribers

OPTUMRx®

[1]Defined as 3+ opioid scripts within 120 days period; [4]**MED** – Morphine Equivalent Dose is a relative potency of an opioid to standard of a morphine; Cumulative MED is daily MED or narcotic load across all active opioid prescriptions in a members profile within a 120 day period; [5]JAMA. 2016 Apr 19;315(15):1624-45. [6]MME – Morphine Milligram Equivalent represents a relative potency of an opioid to a morphine dose.

SDM

Jun 19 to Sep 19

Opioid Utilization Snapshot

Opioid Claims

8,200

4.0% prescription claims filled for an opioid

0.3% higher than Med D benchmark

Utilizers

3,060

36.0% are high utilizers[1]

9.1% lower than high utilizers Med D benchmark

Short acting opioids **62.4%** of opioid Rxs

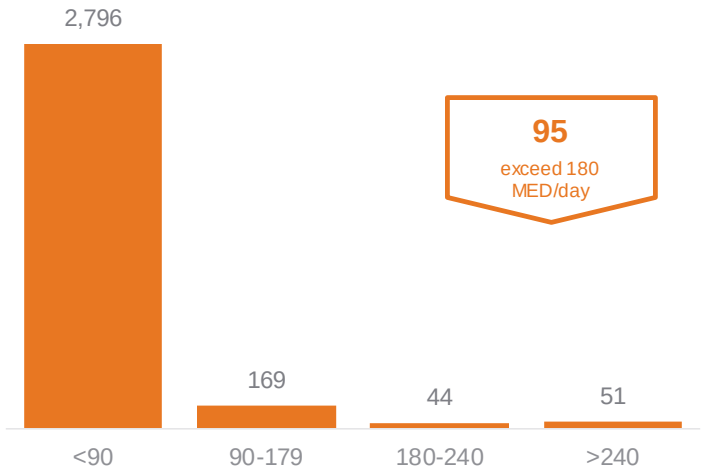
MAT[2] **596** of opioid Rxs

Rescue Therapy[3] 22 Rx(s)

CDC Guidelines advise prescribers to manage pain with lowest effective dose and to avoid or carefully justify doses for chronic users >90mg MME/day

Utilizers by Cumulative MED[4]

Current CDC Guidelines[5] urge doses of 90 MME[6] or less in chronic opioid utilizers[5]



[1]Defined as 3+ opioid scripts within 120 days period; [2]**MAT** - Medication Assisted Therapy (e.g., buprenorphine, etc..); [3] **Overdose Rescue Therapy** – opioid overdose reversal with Narcan (naloxone), etc. [4]**MED** – Morphine Equivalent Dose is a relative potency of an opioid to standard of a morphine; Cumulative MED is daily MED or narcotic load across all active opioid prescriptions in a members profile within a 120 day period; [5]JAMA. 2016 Apr 19;315(15):1624-45. [6]MME – Morphine Milligram Equivalent represents a relative potency of an opioid to a morphine dose.

SDM

Jun 19 to Sep 19

Opioid Utilization Opportunity Assessment

Shoppers: Poly Pharmacy

48

opioid utilizing members with 3+ pharmacies

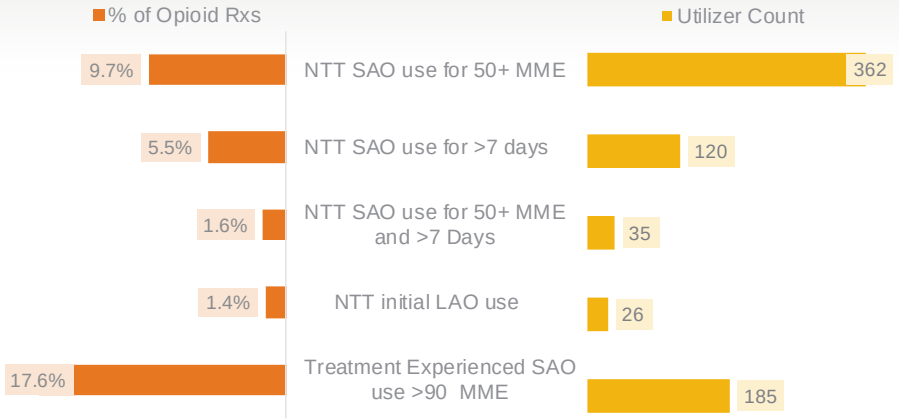
Shoppers: Poly Prescriber

193

opioid utilizing members with 3+ prescribers

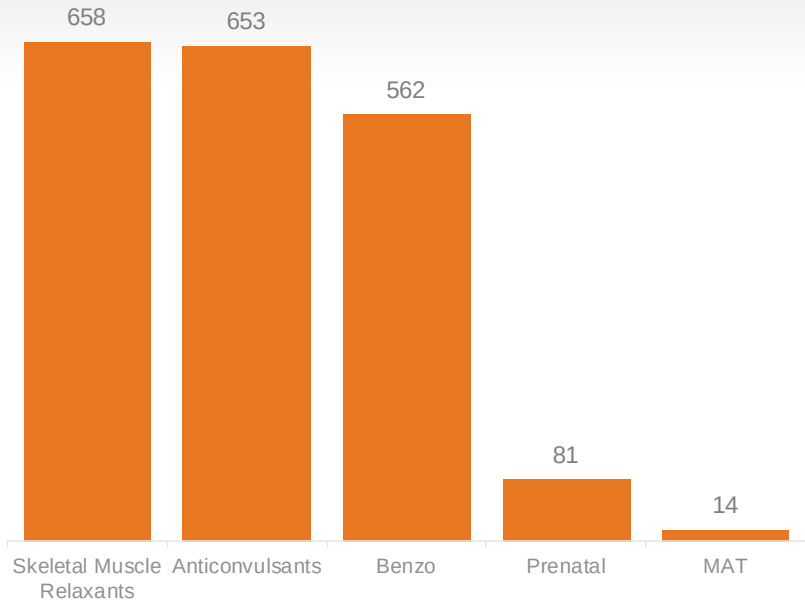
14.8%
of all Opioid Rxs

Non-Compliance to CDC Guidelines[7] for Opioid Prescriptions (NTT[8] and Chronic)



A retrospective review of claims indicates that **467 utilizing members** during this timeframe would have hit our opioid fill UMs if program was implemented.

Utilizers with Opioid Medication Combinations[9]



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[7] JAMA. 2016 Apr 19;315(15):1624-45. doi: 10.1001/jama.2016.1464; [8] NTT – New To Therapy SAO – Short Acting Opioid; LAO – Long Acting Opioid; [9] Anticonvulsants - gabapentin, pregabalin, anticonvulsant benzodiazepines (clobazam, clonazepam, diazepam)

Field Definitions

Dashboard is based on the 120 days of most recent history claims.

Opioid Utilization Snapshot

Opioid claims – total number of opioid claims identified within most recent 120 days claims history
% of Opioid claims - % of opioid claims out of total claims with the period
Benchmark % (claims)- indicates percent difference of your prescription claims filled for an opioid in comparison to segment benchmark
% of Short Acting Opioids – percent of SAO scripts out of total opioid scripts
MAT Rxs – a number of Medication Assisted Therapy (e.g., buprenorphine, etc.) scripts out of total opioid scripts
Rescue Therapy – a number of Rxs for opioid overdose reversal with Narcan (naloxone), etc
Utilizer count – total number of utilizers with opioid Rxs within the period
% of high utilizers - % of utilizers with 3+ opioid scripts within 120 days period
Benchmark % (utilizers)- indicates percent difference of your opioid utilizers in comparison to segment benchmark
Utilizers by Cumulative MED (graph) - Morphine Equivalent Dose is relative potency of an opioid to standard of morphine; Cumulative MED is daily MED or narcotic load across all active opioid prescriptions in a members profile within a 120 day period; **[Total call out]** is a sum of utilizers with 180+ MED.
MME – Morphine Milligram Equivalent represents a relative potency of an opioid to a morphine dose.

Opioid Utilization Opportunity Assessment

Shoppers: Poly Pharmacy – a number of opioid utilizing members with 3 or more pharmacies
Shoppers: Poly Prescriber – a number of opioid utilizing members with 3 or more prescribers
Non-Compliance to CDC Guidelines for Opioid Prescriptions (NTT and Chronic) (graph) – depicts a number of members and % opioid Rxs for New To Therapy (NTT) and chronic opioid use for each of the defined categories; **% Total** – indicates total percent of opioid scripts for the categories.
Retrospective members (call out) - a retrospective review of claims indicating the number members that would have hit Orx opioid fill UMs if program was implemented during the reporting time period.
Opioid Medication Combinations of High-Risk (graph) – depicts a number of opioid utilizers for each opioid/drug type combination.

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Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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?

_____

_____

_____

_____

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: DAW_SouthDakotaMedicaid_2017May-P

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Fax to 1-844-403-1029
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?

_____

_____

_____

_____

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: General_SouthDakotaMedicaid_2017May-P

DSS
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Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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?

_____

_____

_____

_____

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: MaxUnitsOverride_SouthDakotaMedicaid_2017May-P

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Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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?

_____

_____

_____

_____

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: HighDollar-ClaimDollarOverride_SouthDakotaMedicaid_2017May-P

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Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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 1-844-403-1029.

Office use only: TopicalAcneAgents_SouthDakotaMedicaid_2018Jul-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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?

_____

_____

_____

_____

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: 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 1-844-403-1029
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 Staphylococus 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 1-844-403-1029.

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 1-844-403-1029
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?

_____

_____

_____

_____

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: Anticoagulants_SouthDakotaMedicaid_2019Nov-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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 of within the past 12 months: _____

_____

For Drizalma Sprinkle, 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 1-844-403-1029.

Office use only: Antidepressants_SouthDakotaMedicaid_2019Nov-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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 1-844-403-1029.

Office use only: AtypicalAntipsychotics_SouthDakotaMedicaid_2019Nov-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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 1-844-403-1029.

Office use only: Akynzeo_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 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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 1-844-403-1029.

Office use only: Chewable-Liquid-ODT-NonSedatingAntihistamines_SouthDakotaMedicaid_2018Apr-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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?

_____

_____

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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 1-844-403-1029.

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 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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?

_____

_____

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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 1-844-403-1029.

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 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Aimovig™, Ajovy™, Emgality™ 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:

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

Clinical information:

Is the requested medication prescribed by or in consultation with a neurologist or pain/headache specialist? ❑ **Yes** ❑ **No**

Will the requested medication be used in combination with another CGRP inhibitor? ❑ **Yes** ❑ **No**

Select the prophylactic therapies the patient has had a trial and failure, (defined as at least 2 months of therapy with greater than 80% adherence), or an intolerance/contraindication to:

❑ Antidepressants (i.e., venlafaxine or tricyclic antidepressant such as amitriptyline or nortriptyline)
Please specify: _____
❑ Anti-epileptics (i.e., topiramate or divalproex sodium). Please specify: _____
❑ Beta-blockers (i.e., atenolol, propranolol, nadolol, timolol, or metoprolol). Please specify: _____

For chronic migraines, also answer the following:

Has the patient been evaluated for rebound headaches caused by medication overuse (more than 12 doses per month of narcotics, triptans, caffeine, or NSAIDs)? ❑ **Yes** ❑ **No**

If diagnosed, will treatment include a plan to taper off the offending medication? ❑ **Yes** ❑ **No**

Does the patient have greater than or equal to 15 headache days per month, of which at least 8 must be migraine days for at least 3 months? ❑ **Yes** ❑ **No**

For episodic migraines, also answer the following:

Does the patient have 4 to 14 migraines per month (but no more than 14 headache days per month)? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following:

Has the patient experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity? ❑ **Yes** ❑ **No**

Has the use of acute migraine medications (e.g., NSAIDs, triptans, narcotics) decreased since the start of CGRP therapy? ❑ **Yes** ❑ **No**

Is the requested medication prescribed by or in consultation with a neurologist or pain/headache specialist? ❑ **Yes** ❑ **No**

Office use only: Aimovig-Ajovy-Emgality_SouthDakotaMedicaid_2018Oct-P

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

Aimovig™, Ajovy™, Emgality™ 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 1-844-403-1029.

Office use only: Aimovig-Ajovy-Emgality_SouthDakotaMedicaid_2018Oct-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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?

_____

_____

_____

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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 1-844-403-1029.

Office use only: Desoxyn-methamphetamine_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 1-844-403-1029
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?

_____

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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 1-844-403-1029.

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 1-844-403-1029
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?

_____

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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 1-844-403-1029.

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 1-844-403-1029
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?

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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 1-844-403-1029.

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 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Epidiolex® 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:

❑ Seizures associated with Dravet syndrome
❑ Seizures associated with Lennox-Gastaut syndrome (LGS)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is Epidiolex 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 1-844-403-1029.

Office use only: Epidiolex_SouthDakotaMedicaid_2019Jan-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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)? ❑ **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 1-844-403-1029.

Office use only: GenitourinarySmoothMuscleRelaxants_SouthDakotaMedicaid_2019Mar-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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 1-844-403-1029.

Office use only: GLP1Agonists_SouthDakotaMedicaid_2019Mar-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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
- ❑ Growth failure due to panhypopituitarism
- ❑ Growth failure due to Prader-Willi syndrome
- ❑ Idiopathic short stature in children
- ❑ Noonan syndrome
- ❑ Septo-optic dysplasia sequence
- ❑ 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**

Office use only: GrowthHormones_SouthDakotaMedicaid_2018Aug-P

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 screened 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**

Is the diagnosis of panhypopituitarism caused by cranipharyngioma surgery? ❑ **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? ❑ **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**

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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 an 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 screened 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 1-844-403-1029.

Office use only: GrowthHormones_SouthDakotaMedicaid_2018Aug-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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 an 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 1-844-403-1029.

Office use only: Serostim_SouthDakotaMedicaid_2018Jul-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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?

_____

_____

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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 1-844-403-1029.

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

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Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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?

_____

_____

_____

_____

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: Hemangeol_SouthDakotaMedicaid_2017May-P

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Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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 diagnosis below:

❑ Hepatitis C virus infection

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

Clinical information:

Document the patient's genotype: _____

Select if the patient has one of the following:

- ❑ Liver biopsy confirming a Metavir score of F3 or F4, unless medically contraindicated
- ❑ Serum aspartate aminotransferase (AST)-to-platelet ratio 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 brand Epclusa or generic sofosbuvir/velpatasvir, 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**

For brand Harvoni or generic ledipasvir/sofosbuvir, 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 medications:

- ❑ Carbamazepine
- ❑ Oxcarbazepine
- ❑ P glycoprotein (P-gp) inducers (e.g., rifampin, St. John's wort)
- ❑ Phenobarbital
- ❑ Phenytoin
- ❑ Rosuvastatin
- ❑ Tenofovir-containing HIV regimens
- ❑ Tipranavir/ritonavir

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

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For Mavyret, also answer the following:

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

Select if the patient has been previously treated with a regimen containing the following (select all that applies):

- ❑ An HCV NS5A inhibitor
- ❑ An NS3/4A protease inhibitor (PI)
- ❑ Interferon (including pegylated formulations), ribavirin, and/or Sovaldi (sofosbuvir)

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 medications:

- ❑ 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 Vosevi, also answer the following:

Has the patient been previously treated with a regimen containing an NS5A inhibitor? ❑ **Yes** ❑ **No**

Has the patient been previously treated with a regimen containing Sovaldi (sofosbuvir) without an NS5A inhibitor? ❑ **Yes** ❑ **No**

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)

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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?

_____

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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 1-844-403-1029.

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Strong Families - South Dakota's Foundation and Our Future

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

Hydrocodone-acetaminophen (APAP) Products
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)

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

Clinical information:

Does the patient have a diagnosis of cancer in the past 365 days? ❑ **Yes** ❑ **No**

Does the patient have a diagnosis of a terminal illness? ❑ **Yes** ❑ **No**

Does the patient have an illness associated with significant pain (e.g., sickle cell anemia, etc)? ❑ **Yes** ❑ **No**

If **yes**, please list the diagnosis: _____

Does the patient have an injury associated with significant pain? ❑ **Yes** ❑ **No**

If **yes**, please list the diagnosis: _____

Have efforts been made to taper the patient to the lowest effective dose? ❑ **Yes** ❑ **No**

If **yes**, please provide documentation: _____

_____

_____

Reauthorization:

If this is a reauthorization request, answer the following:

Is the prescriber maintaining the most conservative, effective treatment? ❑ **Yes** ❑ **No**

If **yes**, please provide documentation: _____

_____

_____

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Strong Families - South Dakota's Foundation and Our Future

Hydrocodone-acetaminophen (APAP) Products
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 1-844-403-1029.

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

Brand Name narcotics 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)

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**

Clinical information:

Does the patient have a diagnosis of cancer in the past 365 days? ❑ **Yes** ❑ **No**

Does the patient have a diagnosis of a terminal illness? ❑ **Yes** ❑ **No**

Does the patient have an illness associated with significant pain (e.g., sickle cell anemia, etc)? ❑ **Yes** ❑ **No**

If **yes**, please list the diagnosis: _____

Does the patient have an injury associated with significant pain? ❑ **Yes** ❑ **No**

If **yes**, please list the diagnosis: _____

Have efforts been made to taper the patient to the lowest effective dose? ❑ **Yes** ❑ **No**

If **yes**, please provide documentation: _____

_____

_____

Reauthorization:

If this is a reauthorization request, answer the following:

Is the prescriber maintaining the most conservative, effective treatment? ❑ **Yes** ❑ **No**

If **yes**, please provide documentation: _____

_____

_____

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: _____

Office use only: BrandNameNarcotics_SouthDakotaMedicaid_2019Oct-P

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Brand Name narcotics 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 1-844-403-1029.

Office use only: BrandNameNarcotics_SouthDakotaMedicaid_2019Oct-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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**

Does the patient have a diagnosis of cancer in the past 365 days? ❑ **Yes** ❑ **No**

Does the patient have a diagnosis of a terminal illness? ❑ **Yes** ❑ **No**

Does the patient have an illness associated with significant pain (e.g., sickle cell anemia, etc)? ❑ **Yes** ❑ **No**

If **yes**, please list the diagnosis: _____

Does the patient have an injury associated with significant pain? ❑ **Yes** ❑ **No**

If **yes**, please list the diagnosis: _____

Have efforts been made to taper the patient to the lowest effective dose? ❑ **Yes** ❑ **No**

If **yes**, please provide documentation: _____

_____

_____

Reauthorization:

If this is a reauthorization request, answer the following:

Is the prescriber maintaining the most conservative, effective treatment? ❑ **Yes** ❑ **No**

If **yes**, please provide documentation: _____

_____

_____

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: MethadoneProducts_SouthDakotaMedicaid_2018Sep-P

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

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

Opioid Naïve 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 diagnosis of cancer in the past 365 days? ❑ **Yes** ❑ **No**

Does the patient have a diagnosis of a terminal illness? ❑ **Yes** ❑ **No**

Does the patient have an illness associated with significant pain (e.g., sickle cell anemia, major surgery, etc)? ❑ **Yes** ❑ **No**

If **yes**, please list the diagnosis: _____

Does the patient have an injury associated with significant pain? ❑ **Yes** ❑ **No**

If **yes**, please list the diagnosis: _____

Have efforts been made to taper the patient to the lowest effective dose? ❑ **Yes** ❑ **No**

If **yes**, please provide documentation: _____

_____

_____

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: OpioidNaive_SouthDakotaMedicaid_2018Jul-P

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

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

Long Acting and Short Acting Opioid 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 diagnosis of cancer in the past 365 days? ❑ **Yes** ❑ **No**

Does the patient have a diagnosis of a terminal illness? ❑ **Yes** ❑ **No**

Does the patient have an illness associated with significant pain (e.g., sickle cell anemia, etc)? ❑ **Yes** ❑ **No**

If **yes**, please list the diagnosis: _____

Does the patient have an injury associated with significant pain? ❑ **Yes** ❑ **No**

If **yes**, please list the diagnosis: _____

Have efforts been made to taper the patient to the lowest effective dose? ❑ **Yes** ❑ **No**

If **yes**, please provide documentation: _____

_____

_____

Reauthorization:

If this is a reauthorization request, answer the following:

Is the prescriber maintaining the most conservative, effective treatment? ❑ **Yes** ❑ **No**

If **yes**, please provide documentation: _____

_____

_____

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 1-844-403-1029.

Office use only: LAO-SAO_SouthDakotaMedicaid_2019Oct-P

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

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

Morphine Equivalent Dose (MED) Limit 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 diagnosis of cancer in the past 365 days? ❑ **Yes** ❑ **No**

Does the patient have a diagnosis of a terminal illness? ❑ **Yes** ❑ **No**

Does the patient have an illness associated with significant pain (e.g., sickle cell anemia, etc)? ❑ **Yes** ❑ **No**

If **yes**, please list the diagnosis: _____

Does the patient have an injury associated with significant pain? ❑ **Yes** ❑ **No**

If **yes**, please list the diagnosis: _____

Have efforts been made to taper the patient to the lowest effective dose? ❑ **Yes** ❑ **No**

If **yes**, please provide documentation: _____

_____

_____

Reauthorization:

If this is a reauthorization request, answer the following:

Is the prescriber maintaining the most conservative, effective treatment? ❑ **Yes** ❑ **No**

If **yes**, please provide documentation: _____

_____

_____

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: MorphineEquivalentDose_SouthDakotaMedicaid_2018Sep-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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?

_____

_____

_____

_____

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: 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 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Dupixent® 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:

- ❑ Atopic dermatitis
- ❑ Chronic rhinosinusitis with nasal polyposis (CRSwNP)
- ❑ Moderate to severe asthma
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Atopic dermatitis:

Has the patient had a documented trial of a topical corticosteroid, pimecrolimus cream, or tacrolimus ointment within the last 120 days? ❑ **Yes** ❑ **No**

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

Chronic rhinosinusitis with nasal polyposis (CRSwNP):

Does the patient have a diagnosis of inadequately controlled CRSwNP? ❑ **Yes** ❑ **No**

Has the patient had a documented trial of an intranasal corticosteroid (INCS) within the last 120 days? ❑ **Yes** ❑ **No**

Was Dupixent prescribed by or in consultation with an allergist/immunologist, pulmonologist, or otolaryngologist (i.e., ENT)? ❑ **Yes** ❑ **No**

Moderate to severe asthma:

Has the patient had a documented trial of an inhaled corticosteroid (ICS) within the last 120 days? ❑ **Yes** ❑ **No**

Select if the patient has had a documented trial of one of the following controller medications within the last 120 days:

- ❑ Long-acting beta 2 agonist (LABA)
- ❑ LABA/ICS combination
- ❑ Long-acting muscarinic antagonists (LAMA)
- ❑ Leukotriene modifiers
- ❑ Theophylline

Was Dupixent prescribed by or in consultation with an allergist/immunologist or pulmonologist? ❑ **Yes** ❑ **No**

Office use only: Dupixent_SouthDakotaMedicaid_2019Oct-P

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

Dupixent® 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 1-844-403-1029.

Office use only: Dupixent_SouthDakotaMedicaid_2019Oct-P

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

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

Fasenra™ 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 inhaled corticosteroid (ICS) and controlled medication (long-acting beta2 agonist (LABA) or high-dose LABA/ICS combination product or leukotriene receptor antagonist)? ❑ **Yes** ❑ **No**

Is Fasenra prescribed by or in consultation with a rheumatologist, pulmonologist, allergist, or 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?

_____

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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 1-844-403-1029.

Office use only: Fasenra_SouthDakotaMedicaid_2019Jan-W

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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:

❑ Eosinophilic granulomatosis with polyangiitis (Churg-Strauss Syndrome)
❑ Severe asthma with an eosinophilic phenotype
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is Nucala prescribed by or in consultation with a rheumatologist, pulmonologist, allergist, or immunologist? ❑ **Yes** ❑ **No**

For severe asthma with an eosinophilic phenotype, also answer the following:

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?

_____

_____

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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 1-844-403-1029.

Office use only: Nucala_SouthDakotaMedicaid_2019Nov-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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 a positive skin test or in vitro reactivity to a perennial aeroallergen? ❑ **Yes** ❑ **No**
Does the patient have an elevated serum IgE level? ❑ **Yes** ❑ **No**
Are the patient's symptoms inadequately controlled with inhaled corticosteroids? ❑ **Yes** ❑ **No**
Is Xolair prescribed by or in consultation with a pulmonologist, allergist, or immunologist? ❑ **Yes** ❑ **No**

For chronic idiopathic urticaria, answer the following:

Does the patient remain symptomatic despite H1 antihistamine treatment? ❑ **Yes** ❑ **No**
Is Xolair prescribed by or in consultation with a dermatologist, rheumatologist, pulmonologist, allergist, or immunologist? ❑ **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?

_____

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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 1-844-403-1029.

Office use only: Xolair_SouthDakotaMedicaid_2019Oct-P

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

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

Actemra® 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 polyarticular juvenile idiopathic arthritis (pJIA)
- ❑ Active systemic juvenile idiopathic arthritis (sJIA)
- ❑ Chimeric antigen receptor (CAR) T cell-induced severe or life-threatening cytokine release syndrome (CRS)
- ❑ Moderately to severely active rheumatoid arthritis (RA)
- ❑ Temporal arteritis or giant cell arteritis (GCA)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

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

- ❑ Allergist/immunologist
- ❑ Rheumatologist

Will Actemra 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 to, intolerance to, or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs)? ❑ **Yes** ❑ **No**

For active 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 to, intolerance to, or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs)? ❑ **Yes** ❑ **No**

For temporal arteritis or giant cell arteritis (GCA), also answer the following:

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

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

Actemra® 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 1-844-403-1029.

Office use only: Actemra_SouthDakotaMedicaid_2019Mar-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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
- ❑ Moderate to severe chronic plaque psoriasis
- ❑ 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 to, intolerance to, or contraindication 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 to, intolerance to, or contraindication to methotrexate? ❑ **Yes** ❑ **No**

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

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

Office use only: Cimzia_SouthDakotaMedicaid_2018Aug-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

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: Cimzia_SouthDakotaMedicaid_2018Aug-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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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_____

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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 1-844-403-1029.

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 1-844-403-1029
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 to, intolerance to, or contraindication 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 to, intolerance to, or contraindication to methotrexate? ❑ **Yes** ❑ **No**

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

Has the patient had an inadequate response to, intolerance to, or contraindication 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 to, intolerance to, or contraindication 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 to, intolerance to, or contraindication 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
- ❑ 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 1-844-403-1029.

Office use only: Enbrel_SouthDakotaMedicaid_2019Mar-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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 to, intolerance to, or contraindication 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 to, intolerance to, or contraindication to methotrexate? ❑ **Yes** ❑ **No**

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

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

Office use only: Humira_SouthDakotaMedicaid_2019Nov-P

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

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 to, intolerance to, or contraindication 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 to, intolerance to, or contraindication 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 to, intolerance to, or contraindication 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 to, intolerance to, or contraindication 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
❑ 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 1-844-403-1029.

Office use only: Humira_SouthDakotaMedicaid_2019Nov-P

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

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

Ilaris® 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 systemic juvenile idiopathic arthritis

❑ Cryopyrin-associated periodic syndromes (CAPS) [including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells syndrome (MWS)]

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

For active systemic juvenile idiopathic arthritis, answer the following:

Is Ilaris prescribed by or in consultation with a rheumatologist? ❑ **Yes** ❑ **No**

Will Ilaris be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

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 cryopyrin-associated periodic syndromes (CAPS) [including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells syndrome (MWS)], answer the following:

Will Ilaris be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

Is Ilaris diagnosed by, or upon consultation with or recommendation of, an immunologist, allergist, dermatologist, rheumatologist, neurologist, or other medical specialist? ❑ **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 1-844-403-1029.

Office use only: Ilaris_SouthDakotaMedicaid_2019Nov-P

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

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

Ilumya™ 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 Ilumya prescribed by or in consultation with a dermatologist? ❑ **Yes** ❑ **No**

Will Ilumya be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response to, intolerance to, or contraindication 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 1-844-403-1029.

Office use only: Ilumya_SouthDakotaMedicaid_2019Mar-P

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

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

Kevzara® 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 (RA)

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

Clinical information:

Is Kevzara prescribed by or in consultation with a rheumatologist? ❑ **Yes** ❑ **No**

Will Kevzara be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response to, intolerance to, or contraindication 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 1-844-403-1029.

Office use only: Kevzara_SouthDakotaMedicaid_2018Aug-P

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

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

Kineret® 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:

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

For cryopyrin-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**

Will Kineret be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

Is Kineret 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:

Is Kineret prescribed by or in consultation with a rheumatologist? ❑ **Yes** ❑ **No**

Will Kineret be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response to, intolerance to, or contraindication 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
❑ 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 1-844-403-1029.

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

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

Olumiant® 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 (RA)

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

Clinical information:

Is Olumiant prescribed by or in consultation with a rheumatologist? ❑ **Yes** ❑ **No**

Will Olumiant be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response to, intolerance to, or contraindication 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?

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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 1-844-403-1029.

Office use only: Olumiant_SouthDakotaMedicaid_2019Mar-P

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

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

Orencia® 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)
❑ 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 psoriatic arthritis (PsA), also answer the following:

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

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

Has the patient had an inadequate response to, intolerance to, or contraindication 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 to, intolerance to, or contraindication 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
❑ Other: _____

Office use only: Orencia_SouthDakotaMedicaid_2019Mar-P

DSS
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Orencia® 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 1-844-403-1029.

Office use only: Orencia_SouthDakotaMedicaid_2019Mar-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Rinvoq™ 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 (RA)

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

Clinical information:

Is Rinvoq prescribed by or in consultation with a rheumatologist? ❑ **Yes** ❑ **No**

Will Rinvoq be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response to, intolerance to, or contraindication 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?

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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 1-844-403-1029.

Office use only: Rinvoq_SouthDakotaMedicaid_2019Nov-P

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

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

Siliq® 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 chronic plaque psoriasis

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

Clinical information:

Is Siliq prescribed by or in consultation with a dermatologist? ❑ **Yes** ❑ **No**

Will Siliq be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response to, intolerance to, or contraindication 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 1-844-403-1029.

Office use only: Siliq_SouthDakotaMedicaid_2018Aug-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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?

_____

_____

_____

_____

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: Simponi_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 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Skyrizi™ 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 Skyrizi prescribed by or in consultation with a dermatologist? ❑ **Yes** ❑ **No**

Will Skyrizi be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response to, intolerance to, or contraindication 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 1-844-403-1029.

Office use only: Skyrizi_SouthDakotaMedicaid_2019Nov-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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 to, intolerance to, or contraindication to methotrexate? ❑ **Yes** ❑ **No**

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

Has the patient had an inadequate response to, intolerance to, or contraindication 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 to, intolerance to, or contraindication 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
❑ Other: _____

Office use only: Stelara_SouthDakotaMedicaid_2019Mar-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 1-844-403-1029.

Office use only: Stelara_SouthDakotaMedicaid_2019Mar-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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:

- ❑ 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 to, intolerance to, or contraindication 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 to, intolerance to, or contraindication to methotrexate? ❑ **Yes** ❑ **No**

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

Has the patient had an inadequate response to, intolerance to, or contraindication 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 1-844-403-1029.

Office use only: Taltz_SouthDakotaMedicaid_2019Nov-P

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

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

Tremfya® 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 Tremfya prescribed by or in consultation with a dermatologist? ❑ **Yes** ❑ **No**

Will Tremfya be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response to, intolerance to, or contraindication 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 1-844-403-1029.

Office use only: Tremfya_SouthDakotaMedicaid_2019Mar-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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:

- ❑ Active psoriatic arthritis
- ❑ Moderately to severely active rheumatoid arthritis
- ❑ 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 psoriatic arthritis, also answer the following:

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

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

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

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

Has the patient had an inadequate response to, intolerance to, or contraindication 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**

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 1-844-403-1029.

Office use only: Xeljanz-XeljanzXR_SouthDakotaMedicaid_2019Mar-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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 1-844-403-1029.

Office use only: Vusion_SouthDakotaMedicaid_2017May-P

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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
- ❑ Radiculopathy
- ❑ Trigeminal neuralgia
- ❑ 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, fibromyalgia, neuropathic pain associated with postherpetic neuralgia, and trigeminal neuralgia:

Has the patient had a trial and failure, contraindication, or intolerance to a tricyclic antidepressant **OR** an immediate-release gabapentin? ❑ **Yes** ❑ **No**

Partial onset seizure:

Is Lyrica being used as adjunctive therapy? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following:

Is there documentation of positive clinical response to Lyrica therapy? ❑ **Yes** ❑ **No**

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**

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_2018Aug-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 1-844-403-1029.

Office use only: Lyrica_SouthDakotaMedicaid_2018Aug-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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	❑ Copaxone	❑ Glatiramer	❑ Mayzent	❑ Tecfidera
❑ Aubagio	❑ Dalfampridine ER	❑ Glatopa	❑ Mitoxantrone	❑ Tysabri
❑ Avonex	❑ Extavia	❑ Lemtrada	❑ Plegridy	❑ Zinbryta
❑ Betaseron	❑ Gilenya	❑ Mavenclad	❑ Rebif	

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 (dalfampridine ER) only]

For Ampyra (dalfampridine ER), also answer the following:

Does the patient have a history of seizures? ❑ **Yes** ❑ **No**

For Aubagio, Avonex, Betaseron, Copaxone, Extavia, Gilenya, Glatiramer, Glatopa, Lemtrada, Mayzent, Plegridy, Rebif, Tecfidera, or Zinbryta also answer the following:

Does the patient have a relapsing form of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, or active secondary progressive disease? ❑ **Yes** ❑ **No**

For Mavenclad, also answer the following:

Does the patient have a relapsing form of multiple sclerosis, including relapsing-remitting disease or active secondary progressive disease? ❑ **Yes** ❑ **No**

Has the patient already received the FDA-recommended lifetime limit of 2 treatment courses (or 4 treatment cycles total) of cladribine? ❑ **Yes** ❑ **No**

Select the disease-modifying therapies for multiple sclerosis the patient has failed after a trial of at least 4 weeks, has a contraindication to, or intolerance to:

❑ Aubagio (teriflunomide)	❑ Gilenya (fingolimod)	❑ Rebif (interferon beta-1a)
❑ Avonex (interferon beta-1a)	❑ Lemtrada (alemtuzumab)	❑ Tecfidera (dimethyl fumarate)
❑ Betaseron (interferon beta-1b)	❑ Mayzent (siponimod)	❑ Tysabri (natalizumab)
❑ Copaxone/Glatopa (glatiramer acetate)	❑ Ocrevus (ocrelizumab)	❑ Zinbryta (daclizumab)
❑ Extavia (interferon beta-1b)	❑ Plegridy (peginterferon beta-1a)	

DSS
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Multiple Sclerosis Prior Authorization Request Form (Page 2 of 2)

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

For mitoxantrone, also 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

For Tysabri, also answer the following:

Does the patient have a relapsing form of multiple sclerosis? ❑ **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 1-844-403-1029.

Office use only: MultipleSclerosis_SouthDakotaMedicaid_2019Oct-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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:

- ❑ Nasal polyps
- ❑ 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 1-844-403-1029.

Office use only: NasalSteroids_SouthDakotaMedicaid_2018Apr-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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?

_____

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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 1-844-403-1029.

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 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Hetlioz® 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:

❑ Non-24-Hour Sleep-Wake Disorder

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

Medication history:

Has the patient tried and failed a generic sedative-hypnotic (estazolam, eszopiclone, temazepam, triazolam, zaleplon, zolpidem) 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 1-844-403-1029.

Office use only: Hetlioz_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 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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?

_____

_____

_____

_____

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: 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 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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?

_____

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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 1-844-403-1029.

Office use only: Bepreve-Lastacaft-Pataday-Patanol-olopatadine-Pazeo_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 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Oracea®, Seysara®, 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 [**Seysara** and **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 immediate-release, or tetracycline in 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: _____

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: Oracea-Solodyn_SouthDakotaMedicaid_2019Oct-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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 1-844-403-1029.

Office use only: Orkambi_SouthDakotaMedicaid_2018Sep-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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 70 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**

Reauthorization:

If this is a reauthorization request, answer the following:

Is there documentation of positive clinical response to therapy with LDL level less than 70 mg/dl or decreased 30% from baseline? ❑ **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 1-844-403-1029.

Office use only: Praluent-Repatha_SouthDakotaMedicaid_2018Aug-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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, Nexium oral packet, Prevacid Solutab (lansoprazole orally disintegrating tablet [ODT]), Prilosec delayed release suspension pack, Protonix packet, and Zegerid oral packet (omeprazole/sodium bicarbonate oral packet) requests, answer the following:

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

For Dexilant, esomeprazole strontium capsule, Nexium capsule (esomeprazole magnesium capsule), Prevpack oral pack (lansoprazole-amoxicillin-clarithromycin oral pack), 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 1-844-403-1029.

Office use only: ProtonPumpInhibitors_SouthDakotaMedicaid_2019Jul-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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: _____

Office use only: Duexis-Vimovo_SouthDakotaMedicaid_2017May-P

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 1-844-403-1029.

Office use only: Duexis-Vimovo_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 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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?

_____

_____

_____

_____

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: 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 1-844-403-1029
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?

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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 1-844-403-1029.

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 1-844-403-1029
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**

Does the patient have a diagnosis of cancer in the past 365 days? ❑ **Yes** ❑ **No**

Does the patient have a diagnosis of a terminal illness? ❑ **Yes** ❑ **No**

Does the patient have an illness associated with significant pain (e.g., sickle cell anemia, etc)? ❑ **Yes** ❑ **No**

If **yes**, please list the diagnosis: _____

Does the patient have an injury associated with significant pain? ❑ **Yes** ❑ **No**

If **yes**, please list the diagnosis: _____

Have efforts been made to taper the patient to the lowest effective dose? ❑ **Yes** ❑ **No**

If **yes**, please provide documentation: _____

_____

_____

Reauthorization:

If this is a reauthorization request, answer the following:

Is the prescriber maintaining the most conservative, effective treatment? ❑ **Yes** ❑ **No**

If **yes**, please provide documentation: _____

_____

_____

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 1-844-403-1029.

Office use only: UltramER-tramadolER_SouthDakotaMedicaid_2018Sep-P

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

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

Conzip®, Synapryn®, tramadol extended-release (ER) biphasic capsule, tramadol ER biphasic tablet 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)

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**

Does the patient have a diagnosis of cancer in the past 365 days? ❑ **Yes** ❑ **No**

Does the patient have a diagnosis of a terminal illness? ❑ **Yes** ❑ **No**

Does the patient have an illness associated with significant pain (e.g., sickle cell anemia, etc)? ❑ **Yes** ❑ **No**

If **yes**, please list the diagnosis: _____

Does the patient have an injury associated with significant pain? ❑ **Yes** ❑ **No**

If **yes**, please list the diagnosis: _____

Have efforts been made to taper the patient to the lowest effective dose? ❑ **Yes** ❑ **No**

If **yes**, please provide documentation: _____

_____

_____

Reauthorization:

If this is a reauthorization request, answer the following:

Is the prescriber maintaining the most conservative, effective treatment? ❑ **Yes** ❑ **No**

If **yes**, please provide documentation: _____

_____

_____

Office use only: Conzip-Synapryn-tramadolERbiphasiccap-tramadolERbiphasictab_SouthDakotaMedicaid_2018Sep-P

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

Conzip®, Synapryn®, tramadol extended-release (ER) biphasic capsule, tramadol ER biphasic tablet 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 1-844-403-1029.

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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 1-844-403-1029.

Office use only: Triptans_SouthDakotaMedicaid_2019Aug-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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 1-844-403-1029.

Office use only: ODTTriptans_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 1-844-403-1029
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?

_____

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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 1-844-403-1029.

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 1-844-403-1029
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?

_____

_____

_____

_____

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: Uloric_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 1-844-403-1029
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 1-844-403-1029.

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 1-844-403-1029
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?

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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 1-844-403-1029.

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 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Xepi™ 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:

❑ Impetigo due to *Staphylococcus aureus* or *Streptococcus pyogenes*

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

Medication history:

Has the patient had a 10 day trial and failure of mupirocin ointment/cream 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?

_____

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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 1-844-403-1029.

Office use only: Xepi_SouthDakotaMedicaid_2019Jan-P

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

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
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?

_____

_____

_____

_____

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: 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 1-844-403-1029
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 1-844-403-1029.

Office use only: AmbienCR-zolpidemER-Edluar-Intermezzo-zolpidemSL-Zolpimist_SouthDakotaMedicaid_2017May-P

Utilization

Red font denotes drug is on PA

Lyrica – Time frame: October 2018 to June 2019

Drug Name	Total Rx	Paid Amount	Paid/Rx	Utilizing Members	Age Range
LYRICA	1,364	$687,305.77	$503.89	239	11 - 64

Time frame: July 2019 to September 2019

Drug Name	Total Rx	Paid Amount	Paid/Rx	Utilizing Members	Age Range
LYRICA	189	$94,348.28	$499.20	130	11 - 64
pregabalin	238	$6,677.53	$28.06	143	12 - 64
TOTAL	**427**	**$101,025.81**		**170 unique members**	

PA Criteria (fax form pages 109-110):

- Diagnosis of neuropathic pain associated with postherpetic neuralgia, fibromyalgia, or diabetic peripheral neuropathy, trigeminal neuralgia and trial of tricyclic antidepressant or gabapentin
- Diagnosis of partial onset seizure and Lyrica used as adjunctive therapy
- Diagnosis of neuropathic pain associated with spinal cord injury or radiculopathy
- No concomitant gabapentin therapy

Head Lice – Time frame: October 2018 to September 2019

Drug Name	Total Rx	Paid Amount	Paid/Rx	Utilizing Members	Age Range
LINDANE shampoo 1% (lindane)	9	$1,077.51	$119.72	9	3 - 13
NATROBA (spinosad)	1	$236.60	$236.60	1	9
spinosad susp 0.9%	36	$8,152.90	$226.47	32	0 - 12
OVIDE (malathion)	0				
malathion lotion 0.5%	51	$11,508.81	$225.67	39	1 - 34
SKLICE lotion 0.5% (**ivermectin**)	93	$31,852.48	$342.50	79	1 - 36
SOOLANTRA cream 1% (**ivermectin**)	18	$8,784.49	$488.03	13	3, 4, 9, 11 13, 17, 37, 39, 45, 63
permethrin -lice treatment lotion 1% -lice treatment liquid 1% -cream 5%	1,219	$43,071.02	$35.33	967	0 - 81
pyrethrin-piperonyl butoxide -lice killing shampoo 0.33-4%	65	$924.63	$14.23	59	1 - 59
pyrethrin-piperonyl butoxide permethrin -lice solution kit	17	$355.33	$20.90	12	1 - 18
TOTAL	**1,509**	**$105,963.77**			

PA Criteria (fax form page 56):

- Trial of generic OTC products before Rx products

Topical Acne – Time frame: October 2018 to September 2019

Drug Name	Total Rx	Paid Amount	Paid/Rx	Utilizing Members	Age Range
adapalene (Differin)	103	$10,809.61	$104.95	54	9 - 42
Epiduo (adapalene/benzoyl peroxide)					
• Gel 0.1-2.5%	2	$809.76	$404.88	1	16
• Forte Gel 0.3-2.5%	18	$7,643.70	$424.65	12	12 - 18
adapalene/benzoyl peroxide gel 0.1-2.5%	27	$2,134.84	$79.07	20	13 - 20
Azelex cream 20% (azelaic acid)	9	$5,325.48	$591.72	3	17 - 34
benzoyl peroxide gel, wash	51	$849.80	$16.66	28	11 - 19
clindamycin gel, solution, pad	1,992	$111,067.43	$55.76	969	0 - 64
Ery Pad 2% (erythromycin)	3	$262.13	$87.38	2	17 - 29
erythromycin 2% gel, solution	79	$5,465.84	$69.19	59	1 - 57
benzoyl peroxide/erythromycin gel 5-3% (Benzamycin)	179	$19,201.34	$107.27	103	8 - 56
Onexton gel 1.2-3.75	2	$1,066.59	$533.30	1	17
clindamycin/benzoyl peroxide gel 1.2-5%	27	$1,660.03	$61.48	14	13 - 45
clindamycin/benzoyl peroxide gel 1-5%	130	$14,773.17	$113.64	53	12 - 44
Aczone 7.5% gel (dapzone)	14	$8,566.02	$611.86	9	13 - 38
dapsone 5% gel	32	$9,838.84	$307.46	16	13 - 34
sulfacetamide lotion 10%	8	$744.60	$93.08	4	14 - 54
sulfacetamine w/sulfur					
sulfacetamine w/sulfur cream 10-5%	5	$699.62	$139.92	4	16 - 55
sulfacetamine w/sulfur emulsion 10-5%	3	$140.46	$46.82	2	12, 18
sulfacetamine w/sulfur liquid 9.8-4.8%	1	$300.88	$300.88	1	38
sulfacetamine w/sulfur liquid wash	3	$1,172.34	$390.78	1	15
Retin-A; Tretin-X, Atralin (tretinoin)	1	$245.17	$245.17	1	45
tretinoin microsphere (Retin-A Micro gel)	14	$5,022.49	$358.75	11	13 - 48
tretinoin cream, gel	1,326	$144,420.70	$108.91	735	1 - 74
Fabior 0.1% foam (tazarotene)	0				
Tazorac gel, cream (tazarotene)	28	$13,438.92	$479.96	16	13 - 57
tazortene cream 0.1%	11	$1,455.15	$132.29	4	12 - 39
Mirvaso gel 0.33% (brimonidine)	10	$4,716.61	$471.66	5	37 - 59
Finacea Aer/gel 15%	15	$4,746.03	$316.40	11	14 - 41
azelaic acid gel 15%	21	$2,101.91	$100.09	11	13 - 58
Soolantra cream 1%	18	$8,784.49	$488.03	13	3 - 64
Rhofade 1% cream (oxymetazoline)	10	$5,583.37	$558.34	3	15 - 43
metronidazole topical	124	$9,308.37	$75.07	85	1 - 64
TOTAL	**4,266**	**$402,355.69**			

PA Criteria (fax form page 23):

- Trial of generic topical acne agent (benzoyl peroxide, clindamycin phosphate, erythromycin, sulfacetamide sodium/sulfur, tretinoin first

Indications:

- Tazorac cream/gel (tazarotene) – acne vulgaris, facial wrinkles, photo-aging, psoriasis
- Mirvaso gel (brimonidine) – treatment of persistent (nontransient) facial erythema of acne rosacea
- Finacea (azelaic) – acne rosacea, acne vulgaris
- Soolantra cream (ivermectin) – treatment of inflammatory lesions of acne rosacea
- Rhofade cream (oxymetazoline) – treatment of persistent facial erythema associated with acne rosacea
- metronidazole cream, lotion, gel – treatment of acne rosacea

Ophthalmic Antihistamines – Time Frame: October 2018 to September 2019

Drug Name	Total Rx	Paid Amount	Paid/Rx	Utilizing Members	Age Range
BEPREVE (bepotastine drop 1.5%)	0				
LASTACAFT (alcaftadine drop 0.05%)	12	$2,682.76	$223.56	2	32, 47
PATANOL (olopatadine sol 0.1%)	0				
PATADAY (olopatadine sol 0.2%)	8	$1,462.26	$182.78	2	15, 43
PAZEO (olopatadine drop 0.7%)	37	$6,323.52	$170.91	9	12 - 63
olopatadine drops 0.1% olopatadine sol 0.2%	118 11 **142**	$2,979.21 $733.39 **$3,712.60**	$25.25 $66.67	32 11	1 - 63
azelastine drop 0.05%	296	$5,797.52	$19.59	185	1 - 65
emedastine	0				
epinastine	215	$8,722.96	$40.57	104	1 - 64
TOTAL	**839**	**$32,414.22**			

PA Criteria (fax form page 123):

- Trial of generic OTC products before Rx products

Narcolepsy Agents – Time Frame: October 2018 to September 2019

Drug Name	Total Rx	Paid Amount	Paid/Rx	Utilizing Members	Age Range
Nuvigil (armodafinil)	0				
armodafinil	69	$3,118.82	$45.20	11	28 - 64
Provigil (modafinil)	15	$29,661.20	$1,977.41	2	40, 42
modafinil	178	$6,195.26	$34.80	32	4 - 64
Xyrem (sodium oxybate)	11	$90,977.72	$8,270.70	1	36
Sunosi (solriamfetol)	0				
TOTAL	**273**	**$129,953.00**			

PA Criteria (fax forms pages 120-121):

- Nuvigil/Provigil
  - Diagnosis of narcolepsy
  - Diagnosis of excessive sleepiness associated with obstructive sleep apnea/hypopnea
  - Diagnosis of shift work sleep disorder
- Xyrem
  - Diagnosis of narcolepsy with cataplexy
  - Diagnosis of narcolepsy with excessive daytime sleepiness and previous trial of at least one standard stimulant agents

INTRODUCTION

- Narcolepsy is a lifelong neurological sleep disorder of hypersomnia characterized by excessive daytime sleepiness (EDS) and intermittent manifestations of rapid eye movement (REM) sleep during wakefulness. Excessive sleepiness is defined by the International Classification of Sleep Disorders, third edition (ICSD-3) as "daily episodes of an irrepressible need to sleep or daytime lapses into sleep" (*Sateia 2014*).
- Patients with narcolepsy often have many nighttime arousals and sleep disturbances that contribute to excessive drowsiness during the day. EDS can vary in severity, and some patients involuntarily fall asleep during normal daily activities. This can put the patient or others at risk if these daytime lapses into sleep occur during activities such as operating a motor vehicle. While all patients with narcolepsy experience EDS, additional symptoms may include cataplexy, which is the sudden and complete loss of muscle tone, dream-like images or hallucinations at sleep onset or awakening, and sleep paralysis (*National Institute of Neurological Disorders and Stroke [NINDS] 2017, Scammell 2019).*
- The ICSD-3 establishes 2 subtypes of narcolepsy: narcolepsy type 1 and narcolepsy type 2. Patients are diagnosed with narcolepsy type 1 if they have 1 or both of the following: (1) a cerebrospinal fluid (CSF) hypocretin-1 deficiency; (2) clear cataplexy and a mean sleep latency of < 8 minutes on the multiple sleep latency test (MSLT) with evidence of 2 sleep-onset rapid-eye movement periods (SOREMPs), one of which may be seen on a preceding overnight polysomnogram. A diagnosis of narcolepsy type 2 also requires a mean sleep latency of < 8 minutes on the MSLT and at least 2 SOREMPs, but cataplexy must be absent and CSF hypocretin-1 levels must not meet the type 1 criterion *(Sateia 2014).*
- Narcolepsy affects males and females equally. While symptoms typically begin to present in the teens or early twenties, they can occur at any time throughout a patients' life (*NINDS 2017, Scammell 2019*). It is estimated that approximately 135,000 to 200,000 people in the United States (US) are diagnosed with narcolepsy; however, this number may actually be higher as many patients often go undiagnosed (*NINDS 2017).* Narcolepsy is a chronic condition, but does not typically get worse over time. There is no cure for narcolepsy but there are pharmacological and nonpharmacological options that can be implemented to help patients manage their symptoms. The goal of therapy is to mitigate symptoms in order to improve the patient's quality of life (*Morgenthaler et al 2007a, NINDS 2017*).
- This review will focus on 2 wakefulness promoting agents, modafinil (Provigil) and armodafinil (Nuvigil), 1 central nervous system (CNS) depressant agent, sodium oxybate (Xyrem), and 1 dopamine norepinephrine reuptake inhibitor (DNRI), solriamfetol (Sunosi). These 4 medications are approved by the US Food and Drug Administration (FDA) for the symptomatic treatment of narcolepsy. There are several amphetamine-like stimulant medications indicated for the treatment of narcolepsy; however, they will not be covered in this review.
- Modafinil and armodafinil (the longer half-life R-enantiomer of modafinil) are both FDA-approved to improve wakefulness in adult patients with excessive sleepiness associated with narcolepsy, obstructive sleep apnea (OSA), and shift work disorder (SWD). OSA is a sleep disorder that is characterized by obstructive apneas and hypopneas, causing patients to have frequent sleep interruptions due to increased respiratory effort. Often, patients do not feel rested in the morning and continue to have excessive sleepiness throughout the day (*American Academy of Sleep Medicine [AASM] 2009, Strohl 2019*). SWD is a circadian rhythm sleep disorder that occurs in individuals who work non-traditional hours and is characterized by excessive sleepiness and/or insomnia (*Morgenthaler et al 2007b*). Modafinil and armodafinil have been shown to produce psychoactive and euphoric effects similar to CNS stimulants, as well as alterations in mood, perception, thinking and feelings. As a result, these agents are classified as Schedule IV controlled substances.
- Sodium oxybate is gamma-hydroxybutyric acid (GHB), a known drug of abuse. It is FDA-approved for the treatment of EDS and cataplexy in patients ≥ 7 years of age with narcolepsy and is classified as a Schedule III controlled substance for these indications. However, non-medical uses of sodium oxybate are classified under Schedule I. Sodium oxybate carries a boxed warning regarding CNS depression, abuse, and misuse, and may only be dispensed to patients enrolled in the Xyrem Risk Evaluation and Mitigation Strategy (REMS) program using a specially certified pharmacy. Prescribers and patients must also be enrolled in this REMS program (*Xyrem REMS Web site).*
- Solriamfetol is FDA-approved to improve wakefulness in adult patients with EDS associated with narcolepsy or OSA. Solriamfetol is pending U.S. Controlled Substances Act scheduling (*Sunosi dossier 2019*).

- While placebo-controlled (PC) clinical studies document the efficacy of these agents, the exact mechanisms of action are not completely understood. Head-to-head studies are limited, and current clinical guidelines recommend modafinil and sodium oxybate as first-line treatments for EDS and cataplexy, respectively.
- Medispan class: Stimulants – misc.; Anti-cataplectic agents.

Table 1. Medications Included Within Class Review

Drug	Generic Availability
Nuvigil (armodafinil)	✔
Provigil (modafinil)	✔
Sunosi (solriamfetol)	-
Xyrem (sodium oxybate)	-

(*Drugs@FDA 2019, Orange Book: approved drug products with therapeutic equivalence evaluations 2019*)

INDICATIONS

Table 2. Food and Drug Administration Approved Indications

Indication	Nuvigil (armodafinil)	Provigil (modafinil)	Sunosi (solriamfetol)	Xyrem (sodium oxybate)
To improve wakefulness in adult patients with excessive sleepiness associated with narcolepsy, OSA, or SWD	✔	✔		
To improve wakefulness in adult patients with EDS associated with narcolepsy or OSA			✔	
For the treatment of cataplexy and EDS in narcolepsy in patients ≥ 7 years of age				✔

(*Prescribing information: Nuvigil 2018, Provigil 2018, Sunosi 2019, Xyrem 2018*)

- 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

Narcolepsy

- The efficacy of modafinil for EDS associated with narcolepsy was established in 2 multicenter (MC), double-blind (DB), PC, randomized controlled trials (RCTs). In both studies, patients treated with modafinil showed statistically significant improvement in objective measures of excessive sleepiness as measured by the MSLT and Maintenance of Wakefulness Test (MWT); and the subjective Epworth Sleepiness Scale (ESS) compared to placebo ($p < 0.001$ for all endpoints in both studies). Overall clinical condition as rated by the Clinical Global Impression of Change (CGI-C) at the final visit was also significantly improved over baseline for patients treated with modafinil compared to placebo in both studies ($p < 0.005$ and $p < 0.03$) (*US Modafinil in Narcolepsy Multicenter Study Group 1998, US Modafinil in Narcolepsy Multicenter Study Group 2000).*
- The efficacy of armodafinil for EDS associated with narcolepsy was established in a MC, DB, PC, RCT. Patients treated with armodafinil showed a statistically significant enhanced ability to remain awake as measured by the MWT compared to placebo ($p < 0.01$), as well as improvement in overall clinical condition as rated by the CGI-C compared to placebo ($p < 0.0001$). Armodafinil was also associated with statistically significant improvements in memory, attention, and fatigue ($p < 0.05$) (*Harsh et al 2006).*
- The effectiveness of sodium oxybate in the treatment of EDS in patients with narcolepsy was established in 2 MC, DB, PC, RCTs.

- In the first study, patients treated with sodium oxybate 6 and 9 grams per night achieved statistically significant improvements on the ESS, MWT, and CGI-C compared to the placebo group ($p < 0.001$ for all) (*Xyrem International Study Group 2005a*).
- The second study required patients to be taking a stable dose of modafinil before study randomization. Patients were randomized to placebo, sodium oxybate, modafinil, or sodium oxybate plus modafinil. Patients who were switched from modafinil to sodium oxybate did not experience any decrease in sleep latency, suggesting that both medications are equally effective for EDS. Patients taking sodium oxybate alone and sodium oxybate plus modafinil had statistically significant improvements in sleep latency from baseline as measured by MWT compared to the placebo group ($p < 0.001$). The sodium oxybate plus modafinil group showed a significantly greater increase in sleep latency from baseline compared to the sodium oxybate alone group ($p < 0.001$), suggesting that the combination of drugs had an additive effect (*Black & Houghton 2006*).

- The efficacy of sodium oxybate in the treatment of cataplexy in patients with narcolepsy was established in 2 DB, PC, RCTs.
  - In the first study, patients treated with 6 and 9 grams per night saw a significant decrease in cataplexy attacks compared to placebo ($p < 0.05$ for both doses) (*U.S. Xyrem Multicenter Study Group 2002*).
  - The second study was a randomized withdrawal trial including narcoleptic patients already established on sodium oxybate therapy prior to study entry. Patients were randomized to continue treatment with sodium oxybate or to placebo, which included discontinuation of sodium oxybate therapy. Patients who discontinued sodium oxybate experienced a significant increase in cataplexy attacks compared to patients who remained on sodium oxybate ($p < 0.001$) (*U.S. Xyrem Multicenter Study Group 2004*).
- The efficacy of solriamfetol for the treatment of narcolepsy or narcolepsy with cataplexy was evaluated in a DB, PC, MC, RCT (*Thorpy et al 2019*). Patients were stratified on the basis of presence or absence of cataplexy. Cataplexy was present in 50.8% of patients overall, with similar percentages of patients with cataplexy in each of the treatment groups. At week 12, treatment with solriamfetol significantly improved mean sleep latency measured by the MWT vs placebo ($p < 0.0001$) and ESS scores ($p \leq 0.02$). Significantly higher percentages of patients treated with solriamfetol also reported improvements in Patient Global Impression of Change (PGI-C) vs placebo ($p < 0.0001$). There was no clear effect of solriamfetol on the number of cataplexy attacks per week among patients with cataplexy, although this study was not powered or designed to rigorously evaluate the effects of solriamfetol on cataplexy (data not shown).

OSA

- The efficacy of modafinil for EDS associated with OSA was established in 2 DB, PC, RCTs. In both studies, patients treated with modafinil saw a statistically significant improvement in wakefulness compared to placebo ($p < 0.001$ for both) (*Black et al 2005, Pack et al 2001*).
- The efficacy of armodafinil for EDS associated with OSA was established in 2 PC, DB, RCTs. In both studies, patients treated with armodafinil showed a statistically significant improvement in the ability to remain awake as measured by the MWT ($p < 0.001$ and $p = 0.0003$) and overall clinical condition per the CGI-C compared to placebo ($p < 0.001$ and $p = 0.0069$) (*Roth et al 2006, Hirshkowitz et al 2007*).
- The efficacy of solriamfetol for the treatment of EDS in patients with OSA with current or prior sleep apnea treatment was demonstrated in a DB, PC, MC, RCT (*Schweitzer et al 2018*). At week 12, solriamfetol-treated patients had significantly greater improvements in mean sleep latency assessed by the MWT ($p < 0.001$) and ESS score ($p \leq 0.02$). At week 12, higher percentages of patients on solriamfetol reported overall improvement on the PGI-C vs placebo ($p < 0.0001$).
- A randomized withdrawal study evaluated the maintenance of efficacy and safety of solriamfetol vs placebo for the treatment of EDS in adults with OSA (*Strollo et al 2019*). After 2 weeks of clinical titration and 2 weeks of stable dose administration, patients who reported “much improved” or “very much improved” on the PGI-C and had numerical improvements on the MWT and ESS were randomly assigned to placebo or solriamfetol for 2 additional weeks. From baseline to week 4, mean sleep latency on the MWT and ESS scores improved. From weeks 4 to 6 (randomized withdrawal phase), solriamfetol-treated patients maintained improvements in MWT and ESS. During the randomized withdrawal phase, more patients who were switched to placebo reported worsening on the PGI-C and CGI-C vs those who continued solriamfetol.

- An OL extension study evaluated the long-term safety and maintenance of efficacy of solriamfetol for up to 52 weeks in the treatment of patients with narcolepsy or OSA who completed previous trials of solriamfetol (*Sunosi dossier 2019*). In

a 2-week OL titration phase, patients received solriamfetol, titrated to a maximum tolerated dose, followed by a maintenance phase. During a 2-week PC randomized withdrawal phase ~6 months later, patients were randomized either to placebo or to continue their maintenance solriamfetol dose for 2 weeks. From the beginning to the end of the randomized withdrawal phase, the ESS score was significantly improved with solriamfetol vs placebo ($p < 0.0001$). The percentage of patients who were reported as worse on the PGI-C at the end of the randomized withdrawal phase was greater for patients randomized to placebo compared to patients on solriamfetol ($p < 0.0001$). Long-term maintenance of efficacy of solriamfetol was demonstrated by sustained reductions in ESS scores. During the randomized withdrawal period, patients did not demonstrate rebound sleepiness or withdrawal after abrupt discontinuation of solriamfetol.

SWD

- The efficacy of modafinil in treating EDS associated with SWD was evaluated in a DB, PC, RCT. Patients treated with modafinil showed a statistically significant improvement in nighttime sleep latency as measured by the MSLT ($p = 0.002$) (*Czeisler et al 2005*).
- The efficacy of armodafinil in treating EDS associated with SWD was evaluated in a DB, PC, RCT. Patients treated with armodafinil showed a statistically significant improvement in sleep latency as measured by nighttime MSLT compared to placebo ($p < 0.001$) (*Czeisler et al 2009*).
- A head-to-head study conducted by Tembe et al compared armodafinil to modafinil in patients with SWD. The study compared the response rate, defined as the proportion of patients showing ≥ 2 grades of improvement based on the Stanford Sleepiness Score (SSS). After 12 weeks of therapy, there was no statistically significant different in response rates between patients treated with armodafinil vs modafinil ($p = 0.76$). Compliance to therapy and adverse events (AEs) were also similar between groups ($p = 0.63$ and $p = 0.78$, respectively) (*Tembe et al 2011*).

- Armodafinil, modafinil, sodium oxybate, and solriamfetol have all been shown to be more effective compared to placebo for their respective FDA-approved indications, as demonstrated by significant improvements in objective and subjective measures of EDS. In addition, sodium oxybate has been shown to significantly reduce the rate of cataplexy attacks in narcolepsy patients compared to placebo. While there is insufficient evidence to suggest that one agent is more efficacious than another, some studies have demonstrated that concurrent therapy with sodium oxybate and modafinil had a greater effect on EDS and wakefulness than either agent on its own, suggesting an additive effect (*Alshaikh et al 2012, Billiard et al 1994, Black & Houghton 2006, Black et al 2010a, Black et al 2010b, Black et al 2016, Broughton et al 1997, Kuan et al 2016, Xyrem International Study Group 2005b, Schwartz et al 2010, Weaver et al 2006).*

CLINICAL GUIDELINES

Narcolepsy:

- The 2007 AASM practice parameters for the treatment of narcolepsy and other hypersomnias of central origin (*Morgenthaler et al 2007a*) recommend pharmacologic therapy based on the diagnosis and targeted symptoms. Most of the agents used to treat EDS have little effect on cataplexy or other REM sleep associated symptoms, while most antidepressants and anticataplectics have little effect on alertness; however, some medications act on both symptoms. Co-administration of 2 or more drug classes may be required in some patients to adequately address their symptoms. Scheduled naps may be beneficial, but seldom suffice as primary therapy for narcolepsy. The guidelines state that modafinil is effective for treatment of EDS due to narcolepsy and sodium oxybate is effective for treatment of cataplexy, EDS, and disrupted sleep due to narcolepsy. Sodium oxybate may be effective for treatment of hypnagogic hallucinations and sleep paralysis. Amphetamine, methamphetamine, dextroamphetamine, and methylphenidate are effective for treatment of EDS due to narcolepsy. Antidepressants (tricyclics, selective serotonin reuptake inhibitors [SSRIs], venlafaxine) may be effective for treatment of cataplexy. Tricyclics, SSRIs, and venlafaxine may be effective treatment for sleep paralysis and hypnagogic hallucinations.
- The European Academy of Neurology (EAN) 2011 guidelines on management of narcolepsy in adults (*Billiard et al 2011*) recommend modafinil as the first-line treatment for EDS associated with narcolepsy when EDS is the most disturbing symptom. Sodium oxybate is recommended when EDS, cataplexy, and poor sleep coexist. The guideline notes that the combination of modafinil and sodium oxybate may be more effective than sodium oxybate alone. Methylphenidate may be an option if the response to modafinil is inadequate; sodium oxybate is not recommended. Naps are best scheduled on a patient-by-patient basis.
- While armodafinil has been shown in clinical studies to be effective for EDS in narcolepsy, its specific place in therapy is not discussed in the current guidelines.

OSA:

- The 2006 AASM practice parameters for the medical therapy of OSA (*Morgenthaler et al 2006*) provide recommendations for patients with OSA who do not adapt well to or respond to initial therapy with continuous positive airway pressure (CPAP), oral appliances, or surgical modification. Dietary weight loss in obese individuals may be beneficial and should be combined with a primary treatment for OSA. Modafinil is recommended for the treatment of residual EDS in OSA patients who have sleepiness despite effective PAP treatment and who are lacking any other identifiable cause for their sleepiness.

SWD:

- The AASM practice parameters for the clinical evaluation and treatment of circadian rhythm sleep disorders (*Morgenthaler et al 2007b*) recommend planned napping before or during the night shift to improve alertness and performance in patients with SWD. Timed light exposure in the work environment and light restriction in the morning, when feasible, is indicated to decrease sleepiness and improve alertness during night shift work. Administration of melatonin prior to daytime sleep is indicated to promote daytime sleep among night shift workers. Hypnotic medications may be used to promote daytime sleep among night shift workers. Carryover of sedation to the nighttime shift with potential adverse consequences for nighttime performance and safety must be considered. Modafinil is indicated to enhance alertness during the night shift for SWD. Caffeine is indicated to enhance alertness during the night shift for SWD.

SAFETY SUMMARY

- Sodium oxybate is contraindicated in patients with succinic semialdehyde dehydrogenase deficiency and when used in combination with sedative hypnotics or alcohol.
- Sodium oxybate carries a boxed warning regarding CNS depression and misuse and abuse.
  - Respiratory depression may occur; the concurrent use of sodium oxybate with other CNS depressants may increase the risk of respiratory depression, hypotension, profound sedation, syncope, and death.
  - As a sodium salt of the Schedule I controlled substance GHB, sodium oxybate abuse or misuse may be associated with CNS AEs including seizure, respiratory depression, decreased levels of consciousness, coma, and death.
  - Because of these risks, sodium oxybate is only available through a restricted distribution program called the Xyrem REMS program using a central pharmacy that is specially certified. Prescribers and patients must also enroll in the program (*Xyrem REMS Web site*).
- Additional warnings and precautions for sodium oxybate include:
  - Patients should avoid participation in hazardous activities requiring complete mental alertness or motor coordination within the first 6 hours of dosing or after first initiating treatment until certain that sodium oxybate does not adversely affect them.
  - Monitor patients for signs of new or increased depression and suicidality, impaired motor and cognitive function, and episodes of sleepwalking.
  - Due to its high sodium content, patients with heart failure, hypertension, or impaired renal function should be routinely monitored while taking sodium oxybate.
- Common AEs with sodium oxybate were nausea, dizziness, vomiting, somnolence, enuresis, and tremor.

- Warnings and Precautions for modafinil and armodafinil include:
  - Cases of serious rash, including Stevens-Johnson Syndrome, have been reported. Discontinue therapy at the first sign of rash unless certain rash is not drug-related.
  - Angioedema and anaphylaxis reactions may occur. Discontinue therapy and immediately seek medical attention at the first signs of angioedema or anaphylaxis.
  - Multi-organ hypersensitivity reactions may occur. There are no known factors to predict the risk of occurrence or the severity of the reaction, and therapy should be discontinued in these patients.
  - Persistent sleepiness: patients should be regularly assessed for degree of sleepiness and advised against driving or other potentially dangerous activities if necessary.
  - The emergence or exacerbation of psychiatric symptoms have been reported; use particular caution in patients with a history of psychosis, depression, or mania.
  - Consider increased monitoring in patients with known cardiovascular disease.

- The most common AEs with modafinil were headache, nausea, nervousness, rhinitis, diarrhea, back pain, anxiety, insomnia, dizziness, and dyspepsia; the most common AEs with armodafinil were headache, nausea, dizziness, and insomnia.
- Drug interactions for modafinil and armodafinil:
  - Exposure to CYP 3A4/5 substrates may be decreased:
    - Effectiveness of steroidal contraceptives may be reduced; use alternative or concomitant contraceptive methods while taking and for 1 month after discontinuation of modafinil or armodafinil.
    - Blood concentrations of cyclosporine may be reduced requiring monitoring and possible dose adjustment.
  - Exposure to CYP2C19 substrates, such as omeprazole, phenytoin, and diazepam, may be increased.
  - More frequent monitoring of prothrombin times/international normalized ratio (INR) should be considered when administered with warfarin.
  - Use caution when concomitantly used with monoamine oxidase inhibitors (MAOIs).

- Solriamfetol is contraindicated with concomitant use of MAOIs, or within 14 days following discontinuation of an MAOI because of the risk of hypertensive reaction.
- Warnings and precautions of solriamfetol include blood pressure and heart rate increases and psychiatric symptoms such as anxiety, insomnia, and irritability.
- The most common AEs in either the narcolepsy or OSA populations were headache, nausea, decreased appetite, insomnia, and anxiety.

DOSING AND ADMINISTRATION

Table 3. Dosing and Administration

Drug	Available Formulations	Route	Usual Recommended Frequency	Comments
Nuvigil (armodafinil)	Tablets	Oral	*Narcolepsy or OSA*: once daily in the morning. *SWD*: once daily, approximately 1 hour prior to the start of the work shift.	The dose should be reduced in patients with severe hepatic impairment and geriatric patients.
Provigil (modafinil)	Tablets	Oral	*Narcolepsy or OSA*: once daily in the morning. *SWD*: once daily, approximately 1 hour prior to the start of the work shift.	Patients with severe hepatic impairment should reduce the dose to one-half the recommended dose. Consider a lower dose in geriatric patients.
Sunosi (solriamfetol)	Tablets	Oral	*Narcolepsy or OSA:* once daily	Renal impairment: dose adjustments required; not recommended for use in patients with end-stage renal disease.
Xyrem (sodium oxybate)	Solution	Oral	Adults: administer nightly in 2 equal divided doses: at bedtime and 2.5 to 4 hours later; titrate to effect as directed	Both doses should be prepared prior to bedtime; dilute each dose with approximately ¼ cup of water in pharmacy-provided vials. Take each dose while in bed and lie down after dosing.

Drug	Available Formulations	Route	Usual Recommended Frequency	Comments
			Pediatrics: weight-based dose administered at bedtime and 2.5 to 4 hours later; titrate to effect as directed.	Patients with hepatic impairment should reduce the starting dose by 50%. When using concomitantly with divalproex sodium, an initial dose reduction of at least 20% is recommended.

See the current prescribing information for full details

CONCLUSION

- Narcolepsy is a chronic neurological condition that causes excessive sleepiness throughout the day. EDS can vary in severity and in the most severe cases patients suddenly fall asleep during normal activities. Patients with narcolepsy present with or without clear evidence of cataplexy (type 1 vs type 2, respectively). There is no cure for narcolepsy and current treatments focus on alleviating symptoms and improving quality of life.
- Current clinical evidence supports the use of modafinil as a first-line agent in treating EDS associated with narcolepsy. Sodium oxybate can be used as a second-line agent for EDS in narcolepsy, but is considered first-line therapy for patients diagnosed with cataplexy. While armodafinil has been shown in clinical studies to be effective in treating narcolepsy-associated EDS, the current clinical guidelines do not discuss a specific place in therapy. Amphetamine, methamphetamine, dextroamphetamine, and methylphenidate are additional treatment alternatives for EDS due to narcolepsy, while TCAs, SSRIs, and venlafaxine are second-line alternatives for patients with cataplexy. Solriamfetol has not yet been incorporated into the guidelines.
- Patients with OSA should be treated with primary CPAP therapy, and then may use modafinil as an adjunctive treatment for residual sleepiness. SWD should be treated by utilizing a planned sleep schedule, including regular naps before and during the work shift; modafinil may be used to enhance wakefulness in these patients.
- While current clinical data indicate that modafinil, armodafinil, sodium oxybate, and solriamfetol are all effective for their respective FDA-approved indications, there is a lack of head-to-head data among these agents. A treatment plan should be individualized for all patients and the risks and benefits should be evaluated before beginning any pharmacological therapy.
- Modafinil, armodafinil, and solriamfetol are oral tablets that are dosed once daily. Sodium oxybate is an oral solution that must be taken at bedtime and repeated 2.5 to 4 hours later. Currently, modafinil and armodafinil are available generically.
- Sodium oxybate carries a boxed warning for the risk of CNS depression, misuse, and abuse. Sodium oxybate is only available through the Xyrem REMS program; patients and prescribers must enroll in the program and sodium oxybate is only dispensed through a specially certified pharmacy.

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INTRODUCTION

- Pain originates from somatic or visceral structures. Somatic pain is localized and typically results from injury or disease of the skin, musculoskeletal structures, and joints. Visceral pain arises from internal organ dysfunction or from functional pathology.
- Pain can be acute or chronic. Acute pain often results from injury or inflammation and may have a survival role and assist in the healing process by minimizing re-injury. In contrast, chronic pain, often defined as pain persisting for longer than 3 to 6 months, may be considered a disease in that it serves no useful purpose (*Cohen et al 2016*).
  - A 2016 study estimated that approximately 50 million adults in the United States have chronic pain, and approximately 20 million have high-impact chronic pain (ie, pain that limits life or work activities on most days). Each year, chronic pain contributes to an estimated $560 billion in direct medical costs, lost productivity, and disability programs (*Dahlhamer et al 2018*).
- Pain may be classified as nociceptive or neuropathic pain.
  - Nociceptive pain, including cancer pain, results from an injury or disease affecting somatic structures such as skin, muscle, tendons and ligaments, bone, and joints. It is typically treated with non-opioid analgesics or opioids.
  - Neuropathic pain results from disease or injury to the peripheral or central nervous systems (CNS). It is often treated with adjuvant drugs such as antidepressants and antiepileptics. Opioids are recommended as second- or third-line agents (*Cohen et al 2016*).
- Several pharmacologic and nonpharmacologic options are currently available for the management of pain. Treatment options include pharmacologic treatment, physical medicine, behavioral medicine, neuromodulation, interventional approaches, and surgery. Pharmacologic therapy should not be the sole focus of pain treatment; however, it is the most widely utilized option (*Cohen et al 2016*).
  - Combining multiple types of pharmacologic and nonpharmacologic therapy is recommended as preferred therapy for chronic noncancer pain (*Dowell et al 2016, The Medical Letter 2018*).
- Major pharmacologic categories used in the management of pain include non-opioid analgesics, tramadol, opioid analgesics (full and partial agonists), alpha-2 (α_2) adrenergic agonists, antidepressants, anticonvulsants, muscle relaxants, N-methyl-d-aspartate (NMDA) receptor antagonists, and topical analgesics. Opioids are available in both short-acting and long-acting or sustained-release formulations (*Cohen et al 2016*).
- Short-acting opioid analgesics are available as single entities and in combination with acetaminophen, aspirin, butalbital, caffeine, carisoprodol, ibuprofen, and naloxone. Acetaminophen, aspirin, and ibuprofen are non-opioid analgesics. Butalbital is a barbiturate, which has anxiolytic and muscle relaxant properties. Caffeine is an analgesic adjuvant, as well as a CNS stimulant. Carisoprodol is a centrally-acting muscle relaxant (*Micromedex 2.0 2019*). Naloxone, when administered orally at the dose available in the combination tablet (0.5 mg) has no pharmacologic activity; however, when administered parenterally at the same dose, it is an effective antagonist to pentazocine and an antagonist to pure opioid analgesics (*Pentazocine and naloxone prescribing information 2019*). The presence of naloxone in this dosage form is intended to prevent the effect of pentazocine if the combination agent is misused by injection.
- In January 2011, the Food and Drug Administration (FDA) recommended that manufacturers of combination products limit the amount of acetaminophen to no more than 325 mg in each dosage form (ie, tablet or capsule) to reduce the risk of liver damage from too much acetaminophen (*FDA Safety Communication 2011*). All products with dosage forms with acetaminophen exceeding 325 mg have since been removed from the market (*FDA Safety Communication 2014*).
- The Controlled Substances Act (CSA) places substances with accepted medical uses into 1 of 4 schedules, with the substances with the highest potential for harm and abuse in Schedule II, and substances with progressively less potential for harm and abuse in Schedules III through V. Substances that are considered Schedule I do not have an accepted medical use.
  - All single-entity agents within this review are Schedule II (C-II) controlled substances except for butorphanol, which is Schedule IV (C-IV), and nalbuphine, which is not considered a controlled substance.
  - Oxycodone and hydrocodone combination products are C-II controlled substances. The codeine and dihydrocodeine tablet combination products are Schedule III (C-III) controlled substances and liquid products are Schedule V (C-V) controlled substances. Pentazocine/naloxone is a C-IV controlled substance.

- It is important that patients receive appropriate pain treatment with careful consideration of the benefits and risks of treatment options. The use of opioid analgesics presents serious risks, including overdose and opioid use disorder. From 1999 to 2014, there were more than 165,000 deaths due to opioid analgesic overdoses in the United States (*Dowell et al 2016*).
- In March 2016, the Centers for Disease Control and Prevention (CDC) issued a guideline for prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. The guideline addresses when to initiate or continue opioids for chronic pain; opioid selection, dosage, duration, follow-up, and discontinuation; and assessing risks and addressing harms of opioid use. The guideline encourages prescribers to follow best practices for responsible opioid prescribing due to the risks of opioid use (*Dowell et al 2016*).
- In December 2018, the U.S. Department of Health & Human Services (HHS) recommended prescribing or co-prescribing naloxone to all patients who are at risk for opioid overdose, including patients receiving opioids at a dosage of 50 milligram morphine equivalents (MME) per day or greater; patients with respiratory conditions who are prescribed opioids; patients who have been prescribed benzodiazepines along with opioids; and patients prescribed opioids who have a non-opioid substance use disorder, report excessive alcohol use, or have a mental health disorder (*HHS 2018*).
- This review focuses on short-acting opioid agonists and their use in the treatment of pain. This review does not include all injectables, although some medications may be available in this formulation. In addition, immediate-release fentanyl products, tapentadol, and tramadol, are covered in other publications and are not covered in this review.
- The agents included in this review are listed in Table 1 and divided by single entity agents and combination products.
- Medispan Class: Opioid Agonists

Table 1. Medications Included Within Class Review

Drug	Generic Availability
Single Entity Agents	
codeine sulfate*	✔
Demerol (meperidine hydrochloride)	✔
Dilaudid (hydromorphone hydrochloride)	✔
morphine sulfate*	✔
Opana (oxymorphone hydrochloride)	✔
Oxaydo†, Roxicodone, RoxyBond (oxycodone hydrochloride)	✔
butorphanol*	✔
nalbuphine hydrochloride*	✔
Combination Products	
Apadaz (benzhydrocodone/acetaminophen)	✔ ‡
ASCOMP with Codeine, Fiorinal with Codeine #3 (codeine/butalbital/aspirin/caffeine)	✔
Tylenol with Codeine (acetaminophen/codeine)	✔
codeine/carisoprodol/aspirin*	✔
Endocet, Nalocet, Percocet, Primlev (oxycodone hydrochloride/acetaminophen)	✔
Fioricet with Codeine (codeine/butalbital/acetaminophen/caffeine)	✔
Hycet*, Lorcet, Lorcet HD, Lorcet Plus, Lortab, Norco, Verdrocet, Vicodin*, Vicodin ES*, Vicodin HP*, Xodol*, Zamicet (hydrocodone bitartrate/acetaminophen)	✔
Ibudone (hydrocodone hydrochloride/ibuprofen)	✔
oxycodone hydrochloride/aspirin*	✔
oxycodone hydrochloride/ibuprofen*	✔
pentazocine/naloxone*	✔
Dvorah, Trezix (dihydrocodeine bitartrate/acetaminophen/caffeine)	✔

*Branded product no longer commercially available
†A generic for Oxaydo is not anticipated until 2025.
‡An authorized generic is commercially available.
(*Drugs@FDA 2019, Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations 2019*)

INDICATIONS

Table 2. Food and Drug Administration Approved Indications for Single Entity Agents

Indication	butorphanol	codeine	hydromorphone	meperidine	morphine	nalbuphine	oxycodone	oxymorphone
Management of mild to moderate pain where treatment with an opioid is appropriate and for which alternative treatments are inadequate		✔						
Management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate	✔		✔	✔	✔	✔	✔	✔
Supplement to balanced anesthesia						✔		
Preoperative and postoperative analgesia						✔		
Obstetrical analgesia during labor and delivery						✔		

(Prescribing information: butorphanol 2019, codeine 2018, Demerol 2018, Dilaudid 2018, morphine sulfate oral solution 2018, morphine sulfate tablets 2018, nalbuphine hydrochloride 2019, Opana 2019, Oxaydo 2018, Roxicodone 2018, RoxyBond 2018)

Table 3. Food and Drug Administration Approved Indications for Combination Products

Indication	acetaminophen/ codeine	benzhydrocodone /acetaminophen	codeine/ butalbital/ acetaminophen/ caffeine	codeine/ butalbital/ aspirin/caffeine	codeine/ carisoprodol/ aspirin	dihydrocodeine/ acetaminophen/ caffeine	hydrocodone/ acetaminophen	hydrocodone/ ibuprofen	oxycodone/ acetaminophen	oxycodone/ aspirin	oxycodone/ ibuprofen	pentazocine/ naloxone
Relief of discomfort associated with acute, painful musculoskeletal conditions in adults					✔							
Relief of mild to moderate pain	✔											
Relief of tension or muscle contraction headache			✔	✔								
Short-term (< 7 days) management of acute to moderate pain											✔	
Short-term (< 10 days) management of acute pain								✔				

Indication	acetaminophen/ codeine	benzhydrocodone /acetaminophen	codeine/ butalbital/ acetaminophen/ caffeine	codeine/ butalbital/ aspirin/caffeine	codeine/ carisoprodol/ aspirin	dihydrocodeine/ acetaminophen/ caffeine	hydrocodone/ acetaminophen	hydrocodone/ ibuprofen	oxycodone/ acetaminophen	oxycodone/ aspirin	oxycodone/ ibuprofen	pentazocine/ naloxone
Short-term (≤ 14 days) management of acute pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate		✔										
Management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate						✔	✔		✔	✔		✔

(Prescribing information: Apadaz 2019, codeine/carisoprodol/aspirin 2018, Dvorah 2018, Fioricet with Codeine 2019, Fiorinal with codeine 2018, Ibudone 2017, Nalocet 2018, Norco 2018, oxycodone/aspirin 2019, oxycodone/ibuprofen 2019, pentazocine/naloxone 2019, Percocet 2018, Primlev 2018, Trezix 2017, Tylenol with codeine 2019)

- 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

- Overall, clinical trials have demonstrated opioids to be more efficacious than placebo for both pain and functional outcomes in patients with nociceptive or neuropathic pain (*Furlan et al 2006*). However, some meta-analyses in non-cancer pain have not found a clinically meaningful difference between opioids, other non-opioid pain medications, and placebo (*Busse et al 2018, Stewart et al 2018*).
  - A systematic review and meta-analysis of 96 randomized controlled trials examined the use of opioids in chronic non-cancer pain. Opioid use was associated with reduced pain compared to placebo (weighted mean difference [WMD], -0.69 cm on a 10-cm visual analog scale; 95% confidence interval [CI], -0.82 to -0.56 cm; $p < 0.001$), as well as improved physical functioning as measured by the 36-item Short Form physical component score (SF-36 PCS; WMD, 2.04 points on a 100-point scale; 95% CI, 1.41 to 2.68 points; $p < 0.001$). However, the minimally important difference (pain, 1 cm; SF-36 PCS, 5 points) was not reached for either parameter. Opioids were also associated with increased vomiting vs placebo (5.9% vs 2.3%). When opioids were compared to nonsteroidal anti-inflammatory drugs (NSAIDs), similar improvements in pain and physical functioning were observed (pain WMD for opioids vs NSAIDs, -0.60 cm; 95% CI, -1.54 to 0.34; physical functioning WMD for opioids vs NSAIDs, -0.90 points; 95% CI, -2.69 to 0.89) *(Busse et al 2018).* Similarly, another systematic review and meta-analysis of 29 studies found that opioids and other commonly used classes of pain medication produced similar percent reductions in osteoarthritis pain (opioids, 35.4%; oral NSAIDs, 34.3%; topical NSAIDs, 40.9%; acetaminophen, 32.5%; cyclooxygenase-2 [COX-2] inhibitors, 36.9%) *(Stewart et al 2018).*
- Systematic reviews and meta-analyses have demonstrated similar safety and levels of analgesia between hydromorphone, morphine, oxycodone and oxymorphone in the management of cancer, neuropathic, rheumatoid arthritis, osteoarthritis, non-cancer, and acute pain (*Bekkering et al 2011, Caraceni et al 2011, Felden et al 2011, McNicol et al 2005, McNicol et al 2013, Pigni et al 2011, Quigley et al 2002, Reid et al 2006, Wiffen et al 2013, Whittle et al 2011*).
- The results of randomized controlled trials have generally demonstrated a comparable level of analgesia between codeine/acetaminophen, hydrocodone/acetaminophen, hydrocodone/ibuprofen and oxycodone/acetaminophen in the management of pain (*Litkowski et al 2005, Marco et al 2005, Palangio et al 2000[a], Palangio et al 2000[b], Rodriguez et al 2007, Smith et al 2004*).
- Head-to-head trials involving butalbital-containing products and oxycodone/aspirin are not available.
- In April 2017, the FDA approved RoxyBond, a new immediate-release oxycodone formulation. It was approved via the 505(b)(2) pathway with no new clinical efficacy studies. RoxyBond is the first immediate-release opioid analgesic approved with labeling describing its abuse-deterrent properties consistent with the FDA's 2015 Guidance for Industry. The labeling states that there is *in vitro* data demonstrating that RoxyBond has physicochemical properties expected to make abuse via injection difficult. Data from a clinical abuse potential study, along with support from *in vitro* data, also indicate that RoxyBond has physicochemical properties that are expected to reduce abuse by the intranasal route of administration. However, abuse by the intranasal, oral, and intravenous route is still possible (*Roxybond FDA Advisory Committee Briefing Document 2017, RoxyBond Prescribing information 2018).*
  - The manufacturer of Oxaydo (oxycodone) also conducted abuse deterrent studies; however, the FDA labeling states that there is no evidence that Oxaydo has reduced abuse liability compared to immediate-release oxycodone (*Oxaydo Prescribing information 2018)*.
- In February 2018, the FDA approved Apadaz (benzhydrocodone/acetaminophen) via the 505(b)(2) pathway with no new clinical efficacy studies. Benzhydrocodone is an inactive prodrug of hydrocodone and is converted rapidly to hydrocodone by enzymes in the intestinal tract. While Apadaz may have some theoretical benefit in preventing drug manipulation and deterring opioid abuse, there was insufficient *in vitro* and human abuse potential trial data to support an abuse deterrent claim in the labeling *(Apadaz FDA Advisory Committee Briefing Document 2016, Apadaz Prescribing information 2019).*
- A literature search failed to retrieve a significant amount of clinical trial information regarding the safety and effectiveness of pentazocine/naloxone and butorphanol. Specifically, no clinical trial information was obtained for pentazocine/naloxone.
- Butorphanol nasal solution has demonstrated effectiveness and safety in the management of several etiologies of pain including dental pain, postoperative uvulopalatopharyngoplasty pain, postepisiotomy pain, and anal surgery. Open-label trials have demonstrated that administration of butorphanol nasal solution reduces pain and is well-tolerated (*Ladov et al 2000, Madani 2000*). Randomized, placebo-controlled trials demonstrating the effectiveness of butorphanol nasal solution have provided inconsistent results (*Joyce et al 1993, Wermeling et al 2005*). In one study, female patients with moderate to severe postepisiotomy pain achieved superior pain relief with butorphanol nasal solution compared to

placebo; however, no difference was observed in another trial evaluating dental pain. Specifically, no significant differences in summed pain intensity difference (SPID) values through 6 hours post-dose and Total Pain Relief values at 6 hours post-dose were observed between butorphanol nasal solution and placebo (*Wermeling et al 2005*). Additionally, when compared to intramuscular meperidine, treatment with butorphanol nasal solution achieved comparable pain relief but had higher incidences of somnolence, dizziness, and nausea (*Mai et al 2009*). Butorphanol nasal spray also provided superior pain relief to the combination of butalbital, caffeine, aspirin, and codeine, after the first 2 hours when given for migraine pain (*Goldstein et al 1998*).

- Nalbuphine has primarily been studied for analgesia in obstetric and perioperative settings. Three studies have compared nalbuphine to parenteral meperidine for analgesia during labor. Pain relief with nalbuphine was generally comparable to that seen with meperidine, except in 1 study, where nalbuphine produced slightly better analgesia than meperidine when both medications were given via patient-controlled analgesia (*Wilson et al 1986, Frank et al 1987, Dan et al 1991*). Nalbuphine appears to produce comparable pain relief to parenteral meperidine in various perioperative settings (*Brock-Utne et al 1985, Hew et al 1987, Scott 1987, Slattery et al 1986*). Studies comparing nalbuphine to parenteral morphine for perioperative analgesia have had mixed results. One study found that patients receiving nalbuphine for intraoperative and postoperative pain relief during total hysterectomy required fewer supplemental analgesic doses than patients receiving morphine, while 2 other studies in hip surgery and elective arthroscopic surgery found that morphine produced more effective pain relief than nalbuphine during the postoperative period (*Cohen et al 1993, Fee et al 1989, Minai et al 2003*). A study in burn debridement found that nalbuphine and morphine were equally effective for pain relief (*Lee et al 1989*). One study comparing nalbuphine, morphine, and meperidine for patient-controlled analgesia after cholecystectomy found that all 3 medications produced effective pain relief, but pain on movement was less well-controlled with nalbuphine and meperidine vs morphine (*Bahar et al 1985*). Nalbuphine and parenteral pentazocine have also been compared in the perioperative setting, with conflicting results. In 2 studies (1 for minor surgical procedures and 1 for dental procedures), the pain-relieving effects of nalbuphine and pentazocine were not significantly different, but 2 other studies in orthopedic and oral surgery concluded that nalbuphine was more effective for pain relief than pentazocine (*Graham et al 1988, Hook et al 1988, Donadoni et al 1988, Davidson-Lamb 1985*).

CLINICAL GUIDELINES

- Clinical guidelines have been published that address back pain, cancer pain, chronic noncancer pain, neuropathic pain and osteoarthritis pain. These guidelines make recommendations for the specific place in therapy for opioids as a class but do not make any recommendations for the use of one agent over another (*American Academy of Orthopaedic Surgeons [AAOS] 2013, Attal et al 2010, Bril et al 2011, Pop-Busui et al 2017, Chou et al 2007, Chou et al 2009, Hochberg et al 2012, MacFarlane et al, 2017, Manchikanti et al 2017, Qaseem 2017)*. Additional guidelines are available on codeine use in patients with various cytochrome P450 (CYP) 2D6 phenotypes (*Crews et al 2014*).
- In March 2016, the CDC issued a guideline for prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. The guideline addresses when to initiate or continue opioids for chronic pain; opioid selection, dosage, duration, follow-up, and discontinuation; and assessing risk and addressing harms of opioid use. Recommendations in the CDC guideline include the following (*Dowell et al 2016*):
  - Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic noncancer pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with non-pharmacologic therapy and non-opioid pharmacologic therapy, as appropriate (category A, evidence 3).
  - Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety (category A, evidence 4).
  - Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy (category A, evidence 3).
  - When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids (category A, evidence 4).
  - When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing

dosage to ≥ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day (category A, evidence 3).
  - Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than 7 days will rarely be needed (category A, evidence 4).
  - Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids (category A, evidence 4).
  - Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present (category A, evidence 4).
  - Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months (category A, evidence 4).
  - When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs (category B, evidence 4).
  - Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible (category A, evidence 3).
  - Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder (category A, evidence 2).

Category of Recommendations:
- Category A: Applies to all persons; most patients should receive the recommended course of action.
- Category B: Individual decision-making needed; different choices will be appropriate for different patients. Clinicians help patients arrive at a decision consistent with patient values and preferences and specific clinical situations.

Evidence Type:
- Type 1: Randomized clinical trials or overwhelming evidence from observational studies.
- Type 2: Randomized clinical trials with important limitations, or exceptionally strong evidence from observational studies.
- Type 3: Observational studies or randomized clinical trials with notable limitations.
- Type 4: Clinical experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations.

- In February 2017, the American College of Physicians (ACP) published clinical practice guidelines for noninvasive treatments of acute, subacute, and chronic low back pain. The guidelines state that clinicians should only consider opioids as an option in patients who have failed other treatments (eg, non-pharmacological treatment, nonsteroidal anti-inflammatory drugs [NSAIDs], tramadol, duloxetine) and only if the potential benefits outweigh the risks for individual patients and after a discussion of known risks and realistic benefits with patients (*Qaseem et al 2017*).
  - There is moderate-quality evidence that show strong opioids (tapentadol, morphine, hydromorphone, and oxymorphone) are associated with a small short-term improvement in pain scores (about 1 point on a pain scale of 0 to 10) and function compared with placebo. There is moderate-quality evidence that show no differences among different long-acting opioids for pain or function, and low-quality evidence shows no clear differences in pain relief between long- and short-acting opioids.

- In February 2017, the American Society of Interventional Pain Physicians (ASIPP) also published new practice guidelines for responsible, safe, and effective prescription opioids for chronic non-cancer pain. Similar to other guidelines, they do not recommend one opioid agent over the others. They do provide the following recommendations and conclusions for long-term opioid therapy (*Manchikanti et al 2017*):
  - Initiate opioid therapy with low dose, short-acting drugs, with appropriate monitoring (Evidence: Level II; Strength of Recommendation: Moderate).
  - Consider up to 40 MME as low dose, 41 to 90 MME as a moderate dose, and greater than 91 MME as high dose (Evidence: Level II; Strength of Recommendation: Moderate).
  - Avoid long-acting opioids for the initiation of opioid therapy (Evidence: Level I; Strength of Recommendation: Strong).
  - Understand and educate patients of the effectiveness and adverse consequences (Evidence: Level I; Strength of Recommendation: Strong).
  - There is similar effectiveness for long-acting and short-acting opioids with increased adverse consequences of long-acting opioids (Evidence: Level I-II; Strength of recommendation: Moderate to strong).
  - Recommend long-acting or high dose opioids only in specific circumstances with severe intractable pain (Evidence: Level I; Strength of Recommendation: Strong).

- Clinical guidelines provide little information about the role of partial opioid agonists in the treatment of pain (*Chou et al 2009, Hegmann 2014*). Unlike full agonists, the partial agonists have a ceiling on their analgesic effects, and may precipitate withdrawal if given to patients dependent on full opioid agonists (*Medical Letter 2018*).
- The 2 recently published clinical practice guidelines from the ACP and the ASIPP do not discuss the place in therapy of pentazocine, butorphanol, and nalbuphine. Two guidelines on perioperative/postoperative pain management and a guideline on obstetric anesthesia similarly do not discuss the place in therapy for nalbuphine. One guideline from the American College of Obstetricians and Gynecologists (ACOG) mentions that parenteral butorphanol and nalbuphine are commonly used for peripartum analgesia, but it does not recommend a particular drug for use in this setting (*ACOG 2019, American Society of Anesthesiologists Task Force 2012, American Society of Anesthesiologists Task Force 2016, Chou et al 2016*).
- Guidelines from the Society of Critical Care Medicine note that opioids are a mainstay of pain management in most intensive care unit settings; however, they recommend a multimodal approach to analgesia, using non-opioid medications as adjunctive therapy in order to decrease opioid use and optimize pain control. Opioids used for procedural pain management should be used at the lowest effective dose (*Devlin et al 2018*). Similarly, an expert consensus guideline on opioid prescribing in surgical procedures from the American College of Surgeons recommends the maximization of non-opioid analgesia (ie, ibuprofen). It also provides recommendations on the number of oxycodone 5-mg tablets to prescribe after surgery, depending on the type of surgical procedure performed. The maximum recommended number of tablets for any surgical procedure covered in the guideline is 20 tablets, but in some procedures, it is recommended that no opioids be prescribed upon discharge (*Overton et al 2018*).
- A guideline from the Orthopaedic Trauma Association provides recommendations for pharmacologic and nonpharmacologic pain management strategies in acute musculoskeletal injury; this guideline includes detailed recommendations for multimodal analgesia regimens after specific injuries/procedures, as well as tapering schedules for opioid prescriptions (*Hsu et al 2019*).
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SAFETY SUMMARY

- In general, opioids are contraindicated in patients with a hypersensitivity to any component or the active ingredient. They should not be administered to patients with significant respiratory depression, acute or severe bronchial asthma, or suspected or documented paralytic ileus.
- Short-acting opioids that contain acetaminophen, codeine, dihydrocodeine, and ibuprofen carry boxed warnings.
  - Acetaminophen has been associated with acute liver failure, at times resulting in liver transplant and death. Most of the cases of liver injury were associated with the use of acetaminophen at doses that exceeded 4000 mg per day, and often involved more than 1 acetaminophen-containing product.
  - Respiratory depression and death have occurred in children who received codeine following tonsillectomy and/or adenoidectomy and had evidence of being ultra-rapid metabolizers of codeine due to a CYP 2D6 polymorphism. The use of codeine is contraindicated for postoperative pain control in pediatric patients undergoing tonsillectomy or adenoidectomy.

- Cardiovascular risk may be increased with the use of NSAIDs, including serious cardiovascular thrombotic events, myocardial infarction, and stroke, which can be fatal. This risk may increase with duration of use. Patients with cardiovascular disease or risk factors for cardiovascular disease may be at greater risk.
- Gastrointestinal risk is increased with the use of NSAIDs including serious gastrointestinal adverse events (eg, bleeding, ulceration, and perforation of the stomach or intestines), which can be fatal. These events can occur at any time during use and without warning symptoms. Elderly patients are at greater risk for serious gastrointestinal events.

- Adverse events may limit the use of opioid analgesics. The most frequently reported adverse events are light-headedness, dizziness, sedation, nausea, and vomiting (*Micromedex 2.0 2019*).
- In March 2016, the FDA announced label changes and enhanced warnings for all opioids (*FDA Safety Communication 2016*):
  - Among the changes for immediate-release opioids, the FDA is requiring a new boxed warning about the serious risks of misuse, abuse, addiction, overdose, and death. The boxed warning includes a precaution that chronic maternal use of opioids during pregnancy can result in neonatal opioid withdrawal syndrome. Updated indications clarify that immediate-release opioids should be reserved for pain severe enough to require opioid treatment and for which alternative treatment options are inadequate or not tolerated. Updates to the dosing information provide clearer instructions regarding drug administration and patient monitoring, including initial dosage, dosage changes during therapy, and a warning not to abruptly stop treatment in a physically dependent patient. Similar labeling changes were required for ER/LA opioids in 2013.
  - In addition, updated labeling is required for all opioids to include safety information about the risk of adrenal insufficiency; androgen deficiency; and drug interactions with antidepressants and migraine medications that can result in serotonin syndrome. The FDA has issued a drug safety communication describing these risks (*FDA Safety Communication 2016*).
- In August 2016, the FDA announced the addition of boxed warnings to opioid-containing products regarding the serious risks including death when used in combination with benzodiazepines or other drugs that depress the CNS, including alcohol (*FDA Safety Communication 2016*).
  - The FDA recommends that for patients who require concomitant treatment with opioids and benzodiazepines or other CNS depressants due to inadequate treatment alternatives, the dosage and duration of each drug should be limited to the lowest dose possible required for therapeutic effect.
- In September 2017, the FDA notified manufacturers of immediate-release opioid analgesics intended for use in the outpatient setting that these medications will be subject to more stringent requirements under a Risk Evaluation and Mitigation Strategy (REMS), similar to the requirements already in place for extended-release/long-acting opioid analgesics (*Gottlieb 2017*). On September 18, 2018, the long-acting opioid REMS was modified to include all immediate-release opioids as well. This program, now known as the Opioid Analgesic REMS program, strongly encourages healthcare providers to complete an approved training program on opioid analgesics. The goal of the REMS is to ensure that benefits of opioid analgesics outweigh the risks of addiction, abuse, and misuse *(FDA REMS 2018)*. Nalbuphine is not included in the REMS program and is not subject to REMS requirements.
- In April 2019, the FDA issued a drug safety communication regarding the risk of serious harm when opioid medications are suddenly discontinued or doses are rapidly decreased in patients who are physically dependent on opioids. Sudden discontinuation or rapid dose reduction may result in serious withdrawal symptoms, uncontrolled pain, psychological distress, and suicide. Opioid medications should be tapered gradually according to an individualized schedule if discontinuation or dose reduction is necessary (*FDA Safety Communication 2019*).
- The administration of pentazocine, butorphanol, and nalbuphine is not recommended in patients who are dependent on opioids.
- Naloxone when administered orally at the dose available in the combination tablet (0.5 mg) has no pharmacologic activity; however, when administered parenterally at the same dose, it is an effective antagonist to pentazocine and an antagonist to pure opioid analgesics. The presence of naloxone in this dosage form is intended to prevent the effect of pentazocine if the combination agent is misused by injection.
- Other warnings for pentazocine, butorphanol, and nalbuphine are similar to other opioids and include risk of abuse, misuse, diversion, respiratory depression, and adverse events in patients with acute head injury.
- Pentazocine, butorphanol, and nalbuphine should not be used with other substances that may cause CNS depression such as alcohol and sedatives.
- Severe fetal bradycardia has been reported with nalbuphine use during pregnancy; other neonatal adverse events have also been reported, including respiratory depression at birth, apnea, cyanosis, and hypotonia. Only use during labor and delivery if clearly indicated.

DOSING AND ADMINISTRATION

Table 4. Dosing and Administration

Drug	Available Formulations	Route	Usual Recommended Frequency	Comments
Single Entity Agents				
Butorphanol	Nasal solution	Intranasal	1 mg administered as 1 spray in 1 nostril; if adequate pain relief is not achieved within 60 to 90 minutes, an additional 1 mg dose may be given; the initial dose sequence may be repeated in 3 to 4 hours as required	
Codeine sulfate	Tablets	Oral	Every 4 hours as needed	
Dilaudid (hydromorphone hydrochloride)	Solution, tablets	Oral	Solution: Every 3 to 6 hours as required Tablet: Every 4 to 6 hours as needed	
Demerol (meperidine hydrochloride)	Solution, tablets	Oral	Every 3 to 4 hours as needed	
Morphine sulfate	Solution, tablet	Oral	Every 4 hours as needed for pain	
Nalbuphine hydrochloride	Injection solution	Intravenous, Intramuscular, Subcutaneous	Every 3 to 6 hours as needed	
Opana (oxymorphone hydrochloride)	Tablets	Oral	Every 4 to 6 hours as needed	• Contraindicated in moderate and severe hepatic impairment
Oxaydo, Roxicodone, RoxyBond (oxycodone hydrochloride)	Capsules, oral concentrate, solution, tablets, abuse-deterrent tablets	Oral	Every 4 to 6 hours as needed	
Combination Products				
Apadaz (benzhydrocodone/ acetaminophen)	Tablets	Oral	Every 4 to 6 hours as needed	
ASCOMP with codeine, Fiorinal with codeine #3 (codeine/butalbital/ aspirin/caffeine)	Capsules	Oral	Every 4 hours	
Fioricet with codeine (codeine/butalbital/ acetaminophen/ caffeine)	Capsules	Oral	Every 4 hours as needed	
Tylenol-codeine (codeine/ acetaminophen)	Solution, tablets	Oral	Every 4 hours as needed	

Drug	Available Formulations	Route	Usual Recommended Frequency	Comments
Codeine/carisoprodol/ aspirin	Tablets	Oral	Four times daily as needed	• Maximum duration of use is up to 2 or 3 weeks.
Hycet*, Lorcet, Lorcet HD, Lorcet Plus, Lortab, Norco, Verdrocet, Vicodin*, Vicodin ES*, Vicodin HP*, Xodol*, Zamicet (hydrocodone bitartrate/acetaminophen)	Solution, tablets	Oral	Every 4 to 6 hours as needed	
Ibudone (hydrocodone hydrochloride/ibuprofen)	Tablets	Oral	Every 4 to 6 hours as needed	
Endocet, Nalocet, Percocet, Primlev (oxycodone hydrochloride/ acetaminophen)	Solution, tablets	Oral	Every 6 hours as needed	
Oxycodone hydrochloride /aspirin	Tablets	Oral	Every 6 hours as needed	• Avoid use with severe renal impairment. • Avoid use with severe hepatic impairment.
Oxycodone hydrochloride /ibuprofen	Tablets	Oral	Every 6 hours as needed	
Pentazocine/naloxone	Tablet	Oral	Every 3 to 4 hours	
Dvorah, Trezix (dihydrocodeine bitartrate/ acetaminophen/ caffeine)	Capsules, tablets	Oral	Every 4 hours as needed	

(*Micromedex 2.0 2019*)

*Branded product no longer commercially available.

See the current prescribing information for full details

CONCLUSION

- Pain is one of the most common and debilitating patient complaints, with persistent pain having the potential to lead to functional impairment and disability, psychological distress, and sleep deprivation (*Cohen et al 2016*).
- Opioids have been the mainstay of pain treatment for a number of years, and there is well-documented evidence of their effectiveness. Oral morphine is the standard for comparison for all other opioid agents currently available. There are several short-acting opioids that are available as single entity agents and combination products for the treatment of pain (*Cohen et al 2016*).
- As a class, opioid analgesics encompass a group of naturally occurring, semisynthetic, and synthetic drugs that stimulate opioid receptors and effectively relieve pain without producing loss of consciousness. These agents primarily produce intense analgesia via their full and partial agonist actions at mu receptors, which are found in large numbers within the CNS (*Cohen et al 2016, Micromedex 2.0 2019*).
- Short-acting opioid analgesics are available as single entities and in combination with acetaminophen, aspirin, butalbital, caffeine, naloxone, and ibuprofen. Acetaminophen, aspirin, and ibuprofen are non-opioid analgesics. Butalbital is a barbiturate, which has anxiolytic and muscle relaxant properties. Caffeine is an analgesic adjuvant, as well as a CNS stimulant. Carisoprodol is a centrally-acting muscle relaxant (*Micromedex 2.0 2019*). Naloxone, when administered orally at the dose available in the combination tablet (0.5 mg) has no pharmacologic activity; however, when

administered parenterally at the same dose, it is an effective antagonist to pentazocine and an antagonist to pure opioid analgesics (*Pentazocine and naloxone prescribing information 2019*).

- Overall, clinical trials have demonstrated opioids to be more efficacious than placebo for both pain and functional outcomes in patients with nociceptive pain, neuropathic pain, or fibromyalgia (*Furlan et al 2006*). However, some meta-analyses in non-cancer pain have not found a clinically meaningful difference between opioids, other non-opioid pain medications, and placebo (*Busse et al 2018, Stewart et al 2018*).
- Systematic reviews and meta-analyses have demonstrated similar safety and level of analgesia between hydromorphone, morphine, oxycodone, and oxymorphone in the management of cancer, neuropathic, rheumatoid arthritis, osteoarthritis, non-cancer, and acute pain (*Bekkering et al 2011, Caraceni et al 2011, Felden et al 2011, McNicol et al 2005, McNicol et al 2013, Pigni et al 2011, Quigley et al 2002, Reid et al 2006, Wiffen et al 2013, Whittle et al 2011*).
- The results of randomized controlled trials have generally demonstrated a comparable level of analgesia between codeine/acetaminophen, hydrocodone/acetaminophen, hydrocodone/ibuprofen, and oxycodone/acetaminophen in the management of pain (*Litkowski et al 2005, Marco et al 2005, Palangio et al 2000[a], Palangio et al 2000[b], Rodriguez et al 2007, Smith et al 2004*).
- As a rule, opioids are contraindicated in patients with a hypersensitivity to the active ingredient or any component, respiratory depression, acute or severe bronchial asthma, or suspected or documented paralytic ileus. Opioids have an associated abuse potential and can cause cardiovascular effects, respiratory depression and significant CNS depression, especially when used with other CNS depressants. The most frequently reported adverse events are light-headedness, dizziness, sedation, nausea, and vomiting (*Micromedex 2.0 2019*).
- Clinical guidelines have been published that address back pain, cancer pain, chronic noncancer pain, neuropathic pain, and osteoarthritis pain. These guidelines make recommendations for the specific place in therapy for opioids as a class but do not make any recommendations for the use of one agent over another *(AAOS 2013, Attal et al 2010, Bril et al 2011, Pop-Busui et al 2017, Chou et al 2007, Chou et al 2009, Hochberg et al 2012, MacFarlane et al, 2017, Manchikanti, 2017, Qaseem 2017*). Additional guidelines are available on codeine use in patients with various CYP 2D6 phenotypes (*Crews et al 2014*). A guideline from the CDC has recently been published that addresses the use of chronic pain outside of active cancer treatment, palliative care, and end-of-life care. This guideline emphasizes the use of non-pharmacologic and non-opioid therapies when possible, and notes that clinicians should consider opioid therapy only if the expected benefits for both pain and function are anticipated to outweigh risks to the patient (*Dowell et al 2016*). Guidelines from the Society of Critical Care Medicine note that opioids are a mainstay of pain management in most intensive care settings; however, they recommend a multimodal approach to analgesia, using non-opioid medications as adjunctive therapy in order to decrease opioid use and optimize pain control. Opioids used for procedural pain management should be used at the lowest effective dose (*Devlin et al 2018*). Similarly, an expert consensus guideline on opioid prescribing in surgical procedures from the American College of Surgeons recommends the maximization of non-opioid analgesia (ie, ibuprofen), and provides recommendations on the number of oxycodone 5-mg tablets to prescribe after surgery, depending on the type of surgical procedure performed (*Overton et al 2018*). A guideline from the Orthopaedic Trauma Association provides recommendations for pharmacologic and nonpharmacologic pain management strategies in acute musculoskeletal injury. This guideline includes detailed recommendations for multimodal analgesia regimens after specific injuries/procedures, as well as tapering schedules for opioid prescriptions (*Hsu et al 2019*).
- Limited clinical information regarding the safety and effectiveness of opioid partial agonists within this review is available within the literature, and data are particularly lacking for pentazocine/naloxone. Some clinical trial data are available to demonstrate the effectiveness and safety of butorphanol nasal solution and nalbuphine injection. Clinical guidelines provide little information about the role these agents play in the treatment of pain (*Chou et al 2009, Dowell et al 2016, Hegmann et al 2014, Manchikanti et al 2017, Qaseem et al 2017, American Society of Anesthesiologists Task Force 2012, Chou et al 2016, American Society of Anesthesiologists Task Force 2016, ACOG 2019*). Unlike full agonists, the partial agonists have a ceiling on their analgesic effects, and may precipitate withdrawal if given to patients dependent on full opioid agonists (*Medical Letter 2018*).

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