South Dakota
Department of Social Services

Medicaid P&T Committee Meeting

March 24, 2023

South Dakota Department of Social Services

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South Dakota Department of Social Services

SOUTH DAKOTA
MEDICAID P&T COMMITTEE MEETING
AGENDA

March 24, 2023
1:00 – 3:00 PM CT
12:00 – 2:00 PM MT

Meeting Link:
https://teams.microsoft.com/l/meetup-join/19%3ameeting_ODM5OWRjNWEtMTQzMC00MTgzLWE5ZTEtOWRiNjZmY2M0NGZh%40thread.v2/0?context=%7b%22Tid%22%3a%22db05faca-c82a-4b9d-b9c5-0f64b6755421%22%2c%22Oid%22%3a%22b6efd724-b34e-4a86-b34c-e34f07dd4ceb%22%7d

Join with a video conferencing device
425899727@t.plcm.vc
Video Conference ID: 116 419 500 14

Join by phone
+1 952-222-7450
Phone Conference ID: 645 616 569#

Call to order

Approval of previous meeting minutes

PA update

Review of top 15 therapeutic categories/top 50 drugs

Old business
- **Fleqsuvy & baclofen review**
- **Selgentis & tramadol review**
- **Vuity & pilocarpine review**
- **Opioid update**

New business
- **Dermatological PA review**
- **Mupirocin trend**
- **Epinephrine trend**
- **Review PA forms & criteria**
- **Xelstyrm**

Public input accepted after individual topic discussion
Next meeting date June 9, 2023 & adjournment

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

Friday, December 2, 2022
1:00 – 3:00 pm CT

Members and DSS Staff

Michelle Baack, MD	X	Heather Preuss, MD	X
Dana Darger, RPh, Chair	X	Matthew Stanley, DO	X
Mikel Holland, MD	X	Deidre Van Gilder, PharmD	X
Bill Ladwig, RPh	X	Mike Jockheck, DSS Staff	X
Kelley Oehlke, PharmD	X	Matthew Ballard, DSS Staff	X
Lenny Petrik, PharmD		Sarah Aker, DSS Staff	

Administrative Business

Darger called the meeting to order at 1:02 pm. The minutes of the September meeting were presented. Ladwig made a motion to approve. Holland seconded the motion. The motion was unanimously approved.

Biosimilar presentation

Mike Einodshoder, Chief Pharmacy Officer from OptumRx, provided an in-depth presentation on biosimilars.

Prior Authorization Update (PA) and Statistics

The committee reviewed the PA activity report from July 1, 2022, to September 30, 2022. A total of 1,852 PAs were reviewed of which 117 requests (6.3%) were received via telephone and 1,031 requests (55.7%) were received via fax, and 704 (38%) were reviewed via electronically. There was a 3.4% increase of PAs received compared to the previous quarter. Baack inquired if there were any cost savings from dermatological PA changes made the previous year.

Analysis of the Top 15 Therapeutic Classes and Drug Spend

The committee reviewed the top 15 therapeutic classes by total cost of claims from July 1, 2022, to September 30, 2022. The top five therapeutic classes based on paid amount were atypical antipsychotics, disease-modifying anti-rheumatic agents, skin and mucous membrane agents, cystic fibrosis correctors, and amphetamines. These top 15 therapeutic classes make up 25.27 % of total claims. The committee also reviewed the top 50 drugs based on amount paid and number of claims. The top 50 drugs by amount paid make up 9.64% of total claims. Darger commented on the increase of mupirocin claims during this quarter. A more in-depth analysis was requested which would be aligned with the dermatological PA reviews. The increase of epinephrine paid amount was also discussed. Van Gilder added that the increase may be due to the start of the school year. Past third quarter trends will be reviewed to confirm epinephrine increase. Darger inquired if there was any public comment. There was none.

Old Business

Narrow Therapeutic Index Drugs

The committee reviewed the NTI utilization of claims with DAW 1. Baack made a motion to remove the NTI list. Van Gilder seconded the motion. Darger inquired if there was any public comment. There was none. The motion was approved unanimously. Committee discussed pros and cons to adding electronic

PA to levothyroxine capsules. Baack made another motion to add manual review PA to levothyroxine capsules with no grandfathering. Van Gilder seconded the motion. Darger inquired if there was any public comment. There was none. The motion was approved unanimously.

Performance Measures
Samantha Moon from the Department of Medical Services provided follow up on two Performance Measures that the State is tracking: Follow up Care for Children Prescribed ADHD Medication; Ages 6-12 years old and Metabolic Monitoring for Children and Adolescents on Antipsychotics; Ages 1-17 years old. Baack questioned the lab tests included in the lipid panel. Moon will send list included in the lab tests. Stanley provided insight on antipsychotics prescribed in hospital settings and metabolic testing performed there. A new measure to the CORE Set is the Avoidance of Antibiotic Treatment for Acute Bronchitis which Moon will be presenting in the future.

Opioid update
The committee reviewed 3Q2022 opioid outcomes compared to previous quarters from the opioid initiatives. The opioid figures for 2Q2022 excluded IHS utilization with the last similar comparison during 4Q2019. There was an increase in opioid utilization and utilizers during 2Q2022 with corresponding increase in total eligibility and utilizers. Darger inquired if there was any public comment. There was none.

Adjournment
The next meeting scheduled on March 24, 2023. The June meeting is tentatively scheduled for June 9, 2023. The Committee made a motion to adjourn the meeting, and everyone seconded the motion. The motion passed unanimously, and the meeting adjourned at 3:58 pm.

PA Report
10/1/2022 – 12/31/2022

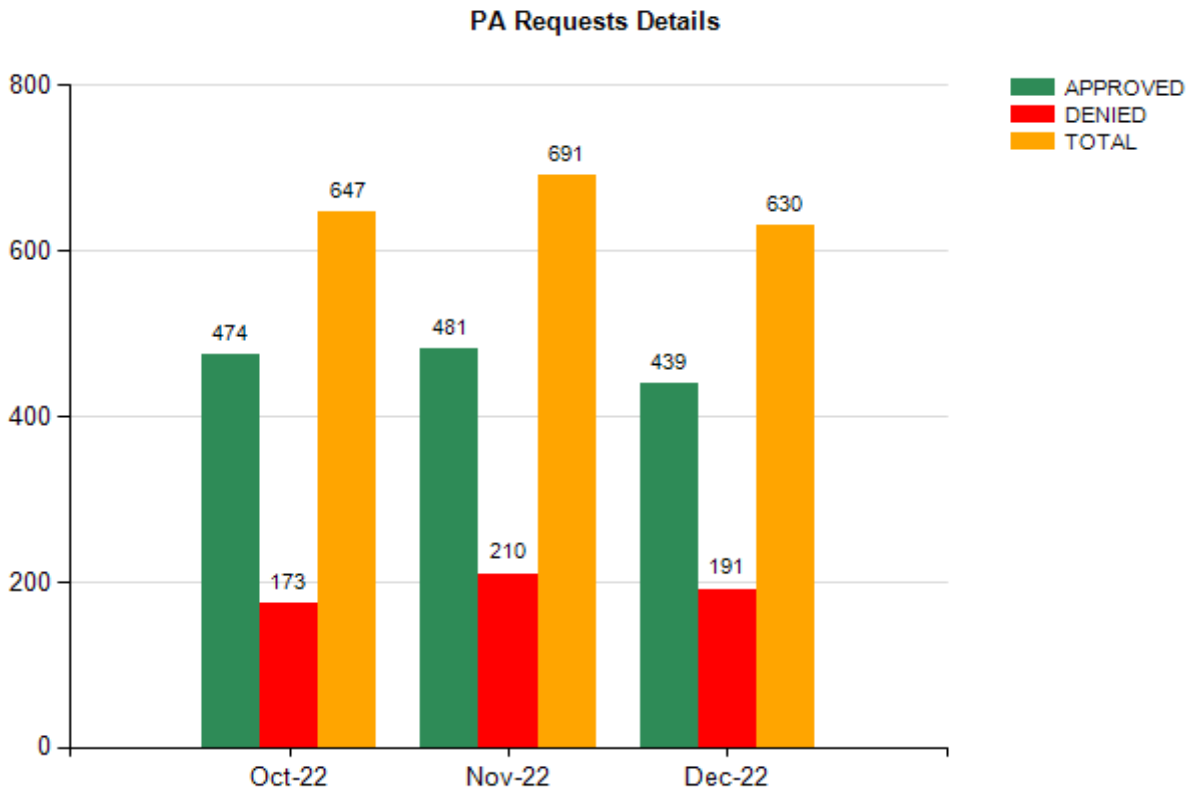
Compliance Summary

Priority	Total PAs	PAs Compliant	PAs Not Compliant	% PAs Compliant	% PAs Not Compliant
Standard	1,922	1,922	0	100.00%	0.00%
Urgent	46	46	0	100.00%	0.00%
Grand Total	**1,968**	**1,968**	**0**		

Drug Class	# of Requests	Phone Requests		Fax Requests		Real-Time PA	
		#	%	#	%	#	%
Total	**1,968**	**100**	**5.1%**	**1,297**	**65.9%**	**571**	**29%**

PA Initial Requests Summary

Month	Approved	Denied	Total
Oct-22	474	173	647
Nov-22	481	210	691
Dec-22	439	191	630
4Q22	**1,394**	**574**	**1,968**
Percent of Total	**7.83%**	**29.17%**	



Top Therapeutic Classes for PA

Drug Class	Approved	Denied	Total	Approval Rate	% of Total Requests	Most Requested Products
ANTIPSYCHOTIC/ANTIMANIC	330	21	351	94.02%	17.84%	, INVEGA SUSTENNA
ANTIDIABETICS	198	122	320	61.88%	16.26%	, OZEMPIC
DERMATOLOGICALS	126	87	213	59.15%	10.82%	DUPIXENT, SPINOSAD
ANTIDEPRESSANTS	160	27	187	85.56%	9.50%	, SERTRALINE
ANALGESICS - OPIOID	83	76	159	52.20%	8.08%	HYDROCODONE/APAP, TRAMADOL
OTHERS -	497	241	738	67.34%	37.50%	
4Q22	**1,394**	**574**	**1,968**	**70.83%**		

PA Drug Class Summary

Drug Class	Approved	Denied	Total	Approval Rate
59 - ANTIPSYCHOTICS/ANTIMANIC AGENTS*	330	21	351	94.02%
27 - ANTIDIABETICS*	198	122	320	61.88%
90 - DERMATOLOGICALS*	126	87	213	59.15%
58 - ANTIDEPRESSANTS*	160	27	187	85.56%
65 - ANALGESICS - OPIOID*	83	76	159	52.20%
67 - MIGRAINE PRODUCTS*	55	42	97	56.70%
52 - GASTROINTESTINAL AGENTS - MISC.*	75	16	91	82.42%
61 - ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREX	56	26	82	68.29%
66 - ANALGESICS - ANTI-INFLAMMATORY*	55	9	64	85.94%
49 - ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERG	44	14	58	75.86%
60 - HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENT	10	38	48	20.83%
16 - ANTI-INFECTIVE AGENTS - MISC.*	29	0	29	100.00%
30 - ENDOCRINE AND METABOLIC AGENTS - MISC.*	18	11	29	62.07%
41 - ANTIHISTAMINES*	21	5	26	80.77%
54 - URINARY ANTISPASMODICS*	17	9	26	65.38%
72 - ANTICONVULSANTS*	18	8	26	69.23%
12 - ANTIVIRALS*	2	20	22	9.09%
21 - ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	16	4	20	80.00%
50 - ANTIEMETICS*	12	3	15	80.00%
75 - MUSCULOSKELETAL THERAPY AGENTS*	5	9	14	35.71%
44 - ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	9	3	12	75.00%
62 - PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENT	11	0	11	100.00%
83 - ANTICOAGULANTS*	9	1	10	90.00%
03 - MACROLIDES*	5	3	8	62.50%
45 - RESPIRATORY AGENTS - MISC.*	4	3	7	57.14%
33 - BETA BLOCKERS*	3	3	6	50.00%
39 - ANTIHYPERLIPIDEMICS*	3	3	6	50.00%
36 - ANTIHYPERTENSIVES*	3	2	5	60.00%
34 - CALCIUM CHANNEL BLOCKERS*	2	2	4	50.00%
02 - CEPHALOSPORINS*	2	1	3	66.67%
42 - NASAL AGENTS - SYSTEMIC AND TOPICAL*	0	3	3	0.00%
82 - HEMATOPOIETIC AGENTS*	3	0	3	100.00%
40 - CARDIOVASCULAR AGENTS - MISC.*	2	0	2	100.00%
51 - DIGESTIVE AIDS*	2	0	2	100.00%
74 - NEUROMUSCULAR AGENTS*	0	2	2	0.00%
86 - OPHTHALMIC AGENTS*	2	0	2	100.00%
15 - ANTHELMINTICS*	1	0	1	100.00%
26 - PROGESTINS*	1	0	1	100.00%
32 - ANTIANGINAL AGENTS*	1	0	1	100.00%
87 - OTIC AGENTS*	1	0	1	100.00%
97 - MEDICAL DEVICES AND SUPPLIES*	0	1	1	0.00%
4Q22	**1,394**	**574**	**1,968**	
Percent of Total	**70.83%**	**29.17%**		

PA Appeals Summary

Month	Approved	Approved %	Denied	Denied %	Total
Oct-22	14	58.33%	10	41.67%	24
Nov-22	15	75.00%	5	25.00%	20
Dec-22	14	37.84%	23	62.16%	37
4Q22	**43**	**53.09%**	**38**	**46.91%**	**81**

Appeals Detail

Drug Class	Approved	Denied	Total	Approval Rate
MAVYRET	2	8	10	20.00%
LUBIPROSTONE	7	1	8	87.50%
EMGALITY	3	2	5	60.00%
EPCLUSA	1	4	5	20.00%
AIMOVIG	2	2	4	50.00%
AJOVY	1	3	4	25.00%
BELSOMRA	2	2	4	50.00%
EPIDIOLEX	2	2	4	50.00%
STELARA	4	0	4	100.00%
OZEMPIC	0	3	3	0.00%
DAYVIGO	0	2	2	0.00%
ESCITALOPRAM OXALATE	0	2	2	0.00%
EVRYSDI	2	0	2	100.00%
NURTEC	1	1	2	50.00%
NUTROPIN AQ NUSPIN 10	1	1	2	50.00%
TRAMADOL HCL	2	0	2	100.00%
ABILIFY MAINTENA	1	0	1	100.00%
AMPHETAMINE/DEXTROAMPHETAMINE	1	0	1	100.00%
CITALOPRAM HYDROBROMIDE	1	0	1	100.00%
DEXLANSOPRAZOLE	1	0	1	100.00%
DUPIXENT	1	0	1	100.00%
HUMATROPE	1	0	1	100.00%
IVERMECTIN	0	1	1	0.00%
METOPROLOL SUCCINATE ER	1	0	1	100.00%
MODAFINIL	1	0	1	100.00%
MOUNJARO	0	1	1	0.00%
MYRBETRIQ	1	0	1	100.00%
NINLARO	1	0	1	100.00%
NORDITROPIN FLEXPRO	1	0	1	100.00%
OTEZLA	0	1	1	0.00%
OXYCONTIN	1	0	1	100.00%
QUVIVIQ	0	1	1	0.00%
TRAMADOL HYDROCHLORIDE	1	0	1	100.00%
TRULICITY	0	1	1	0.00%
4Q22	**43**	**38**	**81**	

Top 15 Therapeutic Classes & Top 50 Drugs

TOP 15 THERAPEUTIC CLASSES BASED ON NUMBER OF CLAIMS FROM 10/1/2022 – 12/31/2022					
	AHFS Description	**Total Rxs**	**Plan Paid Amount**	**Paid/Rx**	**% Total Claims**
1	SELECTIVE-SEROTONIN REUPTAKE INHIBITORS	15,513	$201,897.83	$13.01	6.54%
2	ANTICONVULSANTS, MISCELLANEOUS	12,133	$1,097,018.81	$90.42	5.11%
3	SELECTIVE BETA-2-ADRENERGIC AGONISTS	9,801	$533,319.51	$54.41	4.13%
4	AMINOPENICILLIN ANTIBIOTICS	9,697	$143,948.47	$14.84	4.09%
5	ATYPICAL ANTIPSYCHOTICS	9,658	$3,167,156.70	$327.93	4.07%
6	ADRENALS	8,111	$719,543.10	$88.71	3.42%
7	RESPIRATORY AND CNS STIMULANTS	8,025	$616,317.84	$76.80	3.38%
8	SECOND GENERATION ANTIHISTAMINES	7,870	$88,327.81	$11.22	3.32%
9	AMPHETAMINES	7,682	$1,361,203.93	$177.19	3.24%
10	PROTON-PUMP INHIBITORS	6,656	$179,237.94	$26.93	2.80%
11	OPIATE AGONISTS	5,695	$172,008.20	$30.20	2.40%
12	ANXIOLYTICS, SEDATIVES, AND HYPNOTICS, MISC	5,114	$68,704.07	$13.43	2.16%
13	CENTRAL NERVOUS SYSTEM AGENTS, MISC	4,223	$232,673.39	$55.10	1.78%
14	CONTRACEPTIVES	4,130	$126,873.28	$30.72	1.74%
15	ANTIDEPRESSANTS, MISCELLANEOUS	3,926	$77,785.19	$19.81	1.65%
Total		**118,234**	**$8,786,016.07**	**$74.31**	**49.82%**

TOP 15 THERAPEUTIC CLASSES BASED ON AMOUNT PAID FROM 10/1/2022 – 12/31/2022					
	AHFS Description	**Total Rxs**	**Plan Paid Amount**	**Paid/Rx**	**% Total Claims**
1	ATYPICAL ANTIPSYCHOTICS	9,658	$3,167,156.70	$327.93	4.07%
2	SKIN AND MUCOUS MEMBRANE AGENTS, MISC	750	$2,569,555.81	$3,426.07	0.32%
3	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	381	$2,364,929.47	$6,207.16	0.16%
4	HEMOSTATICS	48	$1,367,604.55	$28,491.76	0.02%
5	AMPHETAMINES	7,682	$1,361,203.93	$177.19	3.24%
6	CYSTIC FIBROSIS (CFTR) CORRECTORS	59	$1,297,418.21	$21,990.14	0.02%
7	ANTICONVULSANTS, MISCELLANEOUS	12,133	$1,097,018.81	$90.42	5.11%
8	INCRETIN MIMETICS	1,122	$952,192.73	$848.66	0.47%
9	ANTINEOPLASTIC AGENTS	283	$896,081.70	$3,166.37	0.12%
10	ADRENALS	8,111	$719,543.10	$88.71	3.42%
11	LONG-ACTING INSULINS	1,445	$619,053.13	$428.41	0.61%
12	RESPIRATORY AND CNS STIMULANTS	8,025	$616,317.84	$76.80	3.38%
13	GI DRUGS, MISCELLANEOUS	423	$580,608.99	$1,372.60	0.18%
14	RAPID-ACTING INSULINS	1,354	$544,513.33	$402.15	0.57%
15	SELECTIVE BETA-2-ADRENERGIC AGONISTS	9,801	$533,319.51	$54.41	4.13%
Total		**61,275**	**$18,686,517.81**	**$304.96**	**25.82%**

Total Rx Claims from 10/1/2022 – 12/31/2022	**237,299**

TOP 50 DRUGS BASED ON NUMBER OF CLAIMS FROM 10/1/2022 – 12/31/2022						
	AHFS Description	**Drug Label Name**	**Total Rxs**	**Plan Paid Amount**	**Paid/Rx**	**% Total Claims**
1↑	AMINOPENICILLIN ANTIBIOTICS	AMOXICILLIN	**7,034**	$93,023.81	$13.22	2.96%
2	SELECTIVE-SEROTONIN REUPTAKE INHIBITOR	**FLUOXETINE**	5,507	$69,833.48	$12.68	2.32%
3	RESPIRATORY AND CNS STIMULANTS	METHYLPHENIDATE HCL	5,401	$267,629.73	$49.55	2.28%
4	SELECTIVE-SEROTONIN REUPTAKE INHIBITOR	**SERTRALINE HCL**	4,853	$59,595.61	$12.28	2.05%
5	SELECTIVE BETA-2-ADRENERGIC AGONISTS	ALBUTEROL SULFATE HFA	4,824	$186,093.46	$38.58	2.03%
6	SECOND GENERATION ANTIHISTAMINES	CETIRIZINE HCL	4,241	$44,128.86	$10.41	1.79%
7	PROTON-PUMP INHIBITORS	**OMEPRAZOLE**	3,958	$45,688.21	$11.54	1.67%
8	AMPHETAMINES	VYVANSE	3,865	$1,235,736.89	$319.72	1.63%
9	SELECTIVE-SEROTONIN REUPTAKE INHIBITORS	ESCITALOPRAM OXALATE	3,669	$46,371.34	$12.64	1.55%
10	AMPHETAMINES	AMPHETAMINE/DEXTROAMP	3,588	$93,892.80	$26.17	1.51%
11	SEROTONIN MODULATORS	TRAZODONE HCL	3,524	$37,622.25	$10.68	1.49%
12	ANTICONVULSANTS, MISCELLANEOUS	GABAPENTIN	3,409	$55,856.78	$16.39	1.44%
13	LEUKOTRIENE MODIFIERS	MONTELUKAST SODIUM	3,398	$44,173.57	$13.00	1.43%
14	THYROID AGENTS	LEVOTHYROXINE SODIUM	3,280	$43,680.79	$13.32	1.38%
15↑	SELECTIVE BETA-2-ADRENERGIC AGONISTS	ALBUTEROL SULFATE	**3,047**	$58,241.67	$19.11	1.28%
16	CENTRAL ALPHA-AGONISTS	**CLONIDINE HCL**	2,999	$37,760.28	$12.59	1.26%
17↑	OTHER MACROLIDE ANTIBIOTICS	AZITHROMYCIN	**2,781**	$45,918.28	$16.51	1.17%
18	ANTIDEPRESSANTS, MISCELLANEOUS	**BUPROPION HCL**	2,731	$50,140.53	$18.36	1.15%
19↑	AMINOPENICILLIN ANTIBIOTICS	AMOXICILLIN/CLAVULANATE	**2,662**	$50,870.81	$19.11	1.12%
20	BIGUANIDES	**METFORMIN HCL**	2,582	$32,008.16	$12.40	1.09%
21	OPIATE AGONISTS	HYDROCODONE BIT/AC	2,317	$35,067.21	$15.13	0.98%
22	ATYPICAL ANTIPSYCHOTICS	ARIPIPRAZOLE	2,302	$33,826.91	$14.69	0.97%
23↑	3RD GENERATION CEPHALOSPORIN ANTIBIOT	CEFDINIR	**2,221**	$45,475.99	$20.48	0.94%
24	ADRENALS	PREDNISONE	2,201	$20,477.31	$9.30	0.93%
25	ANGIOTENSIN-CONVERTING ENZYME INHIBIT	LISINOPRIL	2,187	$21,301.19	$9.74	0.92%
26	HMG-COA REDUCTASE INHIBITORS	ATORVASTATIN CALCIUM	2,185	$25,601.77	$11.72	0.92%
27	1ST GENERATION CEPHALOSPORIN ANTIBIOT	CEPHALEXIN	2,044	$35,097.58	$17.17	0.86%
28	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	GUANFACINE ER	2,043	$35,206.84	$17.23	0.86%
29	SEL. SEROTONIN, NOREPI REUPTAKE INHIBIT	**DULOXETINE HCL**	2,032	$31,926.11	$15.71	0.86%
30	5-HT3 RECEPTOR ANTAGONISTS	ONDANSETRON ODT	1,982	$27,712.62	$13.98	0.84%
31	ANXIOLYTICS, SEDATIVES, & HYPNOTICS	**HYDROXYZINE HCL**	1,898	$23,705.54	$12.49	0.80%
32	ATYPICAL ANTIPSYCHOTICS	RISPERIDONE	1,879	$22,786.17	$12.13	0.79%
33	ANTICONVULSANTS, MISCELLANEOUS	LAMOTRIGINE	1,831	$25,077.84	$13.70	0.77%
34	SECOND GENERATION ANTIHISTAMINES	LORATADINE	1,734	$18,857.15	$10.87	0.73%
35↑	ADRENALS	PREDNISOLONE SODIUM	1,726	$26,852.43	$15.56	0.73%
36	ATYPICAL ANTIPSYCHOTICS	QUETIAPINE FUMARATE	1,587	$20,116.49	$12.68	0.67%
37	CORTICOSTEROIDS (EENT)	FLUTICASONE PROPIONATE	1,569	$23,144.47	$14.75	0.66%
38	ANXIOLYTICS, SEDATIVES, & HYPNOTICS	**BUSPIRONE HCL**	1,550	$19,704.50	$12.71	0.65%
39	BENZODIAZEPINES (ANTICONVULSANTS)	CLONAZEPAM	1,515	$16,735.22	$11.05	0.64%
40↑	NEURAMINIDASE INHIBITOR ANTIVIRALS	OSELTAMIVIR PHOSPHATE	1,442	$49,620.60	$34.41	0.61%
41	COMPOUNDS	-	1,408	$32,355.73	$22.98	0.59%
42	CENTRALLY ACTING SKELETAL MUSCLE RELAX	CYCLOBENZAPRINE HCL	1,354	$13,521.21	$9.99	0.57%
43	ANTICONVULSANTS, MISCELLANEOUS	LEVETIRACETAM	1,331	$27,908.94	$20.97	0.56%
44	PROTON-PUMP INHIBITORS	PANTOPRAZOLE SODIUM	1,292	$16,350.00	$12.65	0.54%
45	CORTICOSTEROIDS-SKIN, MUCOUS MEMBRA	TRIAMCINOLONE ACETONIDE	1,273	$18,478.19	$14.52	0.54%
46	ANTICONVULSANTS, MISCELLANEOUS	TOPIRAMATE	1,263	$16,676.67	$13.20	0.53%
47	DIHYDROPYRIDINES	AMLODIPINE BESYLATE	1,236	$12,176.55	$9.85	0.52%
48↑	RESPIRATORY AND CNS STIMULANTS	DEXMETHYLPHENIDATE HCL	1,213	$57,326.06	$47.26	0.51%
49	ANGIOTENSIN II RECEPTOR ANTAGONISTS	LOSARTAN POTASSIUM	1,184	$13,859.08	$11.71	0.50%
50	ANTIDEPRESSANTS, MISCELLANEOUS	MIRTAZAPINE	1,179	$16,714.98	$14.18	0.50%
	Total Top 50 Drugs		**128,331**	**$3,381,928.66**	**$26.35**	**54.08%**

TOP 50 DRUGS BASED ON AMOUNT PAID FROM 10/1/2022 – 12/31/2022						
	AHFS Description	**Drug Label Name**	**Total Rxs**	**Plan Paid Amount**	**Paid/Rx**	**% Total Claims**
1	DISEASE-MODIFYING ANTIRHEUMATIC AGT	**HUMIRA/PEN & STARTER**	151	$1,310,212.89	$8,676.91	0.06%
2	AMPHETAMINES	VYVANSE	3,865	$1,235,736.89	$319.72	1.63%
3	SKIN & MUCOUS MEMBRANE AGENTS	STELARA	52	$1,184,790.12	$22,784.43	0.02%
4	CYSTIC FIBROSIS (CFTR) CORRECTORS	TRIKAFTA	45	$1,033,075.39	$22,957.23	0.02%
5	ATYPICAL ANTIPSYCHOTICS	**INVEGA SUSTENNA/TRINZA**	335	$942,992.35	$2,814.90	0.14%
6	INTERLEUKIN ANTAGONISTS	**DUPIXENT**	242	$815,348.58	$4,314.01	0.08%
7	ATYPICAL ANTIPSYCHOTICS	LATUDA	473	$615,714.80	$1,301.72	0.20%
8	INCRETIN MIMETICS	OZEMPIC	656	$555,521.28	$846.83	0.28%
9	ATYPICAL ANTIPSYCHOTICS	**ARISTADA & INITIO**	171	$470,760.59	$2,752.99	0.07%
10↑	HEMOSTATICS	NOVOSEVEN RT	4	$461,318.90	$115,329.73	0.00%
11	ATYPICAL ANTIPSYCHOTICS	VRAYLAR	345	$396,294.28	$1,148.68	0.15%
12	ANTICONVULSANTS, MISCELLANEOUS	EPIDIOLEX	121	$353,933.99	$2,925.07	0.05%
13	DISEASE-MODIFYING ANTIRHEUMATIC AGT	**ENBREL & MINI/SURECLICK**	53	$330,139.65	$6,229.05	0.02%
14	HEMOSTATICS	HEMLIBRA	6	$303,221.52	$50,536.92	0.00%
15	SKIN & MUCOUS MEMBRANE AGENTS	TALTZ	38	$288,854.00	$7,601.42	0.02%
16	DISEASE-MODIFYING ANTIRHEUMATIC AGT	**COSENTYX & SENSOREADY**	47	$283,834.62	$6,039.03	0.02%
17	ATYPICAL ANTIPSYCHOTICS	REXULTI	230	$277,463.54	$1,206.36	0.10%
18↑	VESICULAR MONOAMINE TRANSPORT2 INH	INGREZZA	37	$276,269.95	$7,466.76	0.02%
19	RESPIRATORY AND CNS STIMULANTS	METHYLPHENIDATE HCL	5,401	$267,629.73	$49.55	2.28%
20	CYSTIC FIBROSIS (CFTR) CORRECTORS	ORKAMBI	14	$264,342.82	$18,881.63	0.01%
21	SODIUM-GLUC COTRANSPORT 2 INHIBITOR	JARDIANCE	499	$259,269.60	$519.58	0.21%
22	GI DRUGS, MISCELLANEOUS	GATTEX	6	$257,544.00	$42,924.00	0.00%
23	MUCOLYTIC AGENTS	PULMOZYME	59	$250,568.14	$4,246.92	0.02%
24↑	SKIN & MUCOUS MEMBRANE AGENTS	**SKYRIZI & PEN**	13	$234,477.60	$18,036.74	0.01%
25	HIV INTEGRASE INHIBITOR ANTIRETROVIRA	BIKTARVY	66	$229,587.54	$3,478.60	0.03%
26	HEMOSTATICS	ADVATE	8	$204,246.43	$25,530.80	0.00%
27	LONG-ACTING INSULINS	**LANTUS & SOLOSTAR**	505	$199,094.80	$394.25	0.21%
28	INCRETIN MIMETICS	TRULICITY	229	$199,055.87	$869.24	0.10%
29	SELECTIVE BETA-2-ADRENERGIC AGONISTS	ALBUTEROL SULFATE HFA	4,824	$186,093.46	$38.58	2.03%
30↓	SOMATOTROPIN AGONISTS	NORDITROPIN FLEXPRO	54	$181,390.52	$3,359.08	0.02%
31	LONG-ACTING INSULINS	TRESIBA FLEXTOUCH	328	$170,527.56	$519.90	0.14%
32	RIFAMYCIN ANTIBIOTICS	XIFAXAN	64	$158,130.72	$2,470.79	0.03%
33	HEMOSTATICS	RECOMBINATE	3	$150,811.35	$50,270.45	0.00%
34	SKIN & MUCOUS MEMBRANE AGENTS	TREMFYA	12	$149,372.48	$12,447.71	0.01%
35	SELECTIVE BETA-2-ADRENERGIC AGONISTS	ADVAIR HFA	400	$146,902.10	$367.26	0.17%
36	DIRECT FACTOR XA INHIBITORS	**ELIQUIS & STARTER PACK**	242	$145,122.22	$599.68	0.10%
37	GI DRUGS, MISCELLANEOUS	CHOLBAM	7	$140,973.85	$20,139.12	0.00%
38	ATYPICAL ANTIPSYCHOTICS	ABILIFY MAINTENA	57	$135,515.65	$2,377.47	0.02%
39↑	VASODILATING AGENTS (RESPIRATORY)	OPSUMIT	12	$134,325.12	$11,193.76	0.01%
40	HIV INTEGRASE INHIBITOR ANTIRETROVIRA	GENVOYA	37	$129,337.34	$3,495.60	0.02%
41	HEMOSTATICS	XYNTHA SOLOFUSE	4	$128,275.70	$32,068.93	0.00%
42	LONG-ACTING INSULINS	**LEVEMIR & FLEXTOUCH**	263	$122,497.99	$465.77	0.11%
43↑	ANTICONVULSANTS, MISCELLANEOUS	FINTEPLA	7	$121,252.37	$17,321.77	0.00%
44	RAPID-ACTING INSULINS	INSULIN ASPART FLEXPEN	352	$121,037.51	$343.86	0.15%
45↓	OTHER MISCELLANEOUS THERAPEUTIC AGT	EVRYSDI	5	$117,409.25	$23,481.85	0.00%
46↑	ADRENALS	FLUTICASONE PROPIONAT HF	638	$109,919.66	$172.29	0.27%
47	ADRENALS	FLOVENT HFA	477	$109,053.46	$228.62	0.20%
48↑	RESPIRATORY TRACT AGENTS, MISC	XOLAIR	36	$109,009.28	$3,028.04	0.02%
49	ANTIMUSCARINICS/ANTISPASMODICS	SPIRIVA RESPIMAT	230	$105,025.95	$456.63	0.10%
50	RAPID-ACTING INSULINS	NOVOLOG FLEXPEN	174	$101,965.39	$586.01	0.07%
	Total Top 50 Drugs		**21,897**	**$16,475,248.80**	**$752.40**	**9.23%**

Old Business

Fleqsuvy & baclofen

Time frame: 10/1/2022 to 12/31/2022

Drug Name	Total Rx	Paid Amount	Paid/Rx	Avg Quantity/DS	Utilizers	Age Range
baclofen tab 5mg	63	$1,775.60	$28.18	#79/26 days	29	2 – 63
baclofen tab 10mg	699	$9,796.46	$14.02	#91/27 days	309	2 – 72
baclofen tab 20mg	171	$3,294.51	$19.27	#99/29 days	68	5 – 64
baclofen sol 5mg/5ml	22	$10,046.57	$456.66	#428/27 days	10	2 – 26
FLEQSUVY susp 25mg/5ml	26	$30,117.30	$1,158.36	#209/28 days	9	2 – 26
LYVISPAH granules (5mg, 10mg, 20mg)	0					
OZOBAX solution 5mg/5ml*	0					

*not rebateable manufacturer

Indications:

- Solution (Ozobax), tablet: Management of reversible spasticity associated with multiple sclerosis or spinal cord lesions.
- Granules (Lyvispah), suspension (Fleqsuvy): Treatment of spasticity resulting from multiple sclerosis, particularly for the relief of flexor spasms and concomitant pain, clonus, and muscular rigidity; may also be of some value in patients with spinal cord injuries and other spinal cord diseases.

State A: PA criteria for baclofen solution:

1. *Member is 12 to 17 years of age or unable to swallow tablets OR*
2. *Try baclofen tab, chlorzoxazone, cyclobenzaprine IR, methocarbamol, orphenadrine, tizanidine tabs first*
3. *Age 18 and over: provide rationale for not being able to swallow*

State A: PA criteria for Fleqsuvy, and Lyvispah:

1. *Member is 12 to 17 years of age or unable to swallow tablets OR*
2. *Try baclofen tab, chlorzoxazone, cyclobenzaprine IR, methocarbamol, orphenadrine, tizanidine tabs first*
3. *Try baclofen solution first*
4. *Age 18 and over: provide rationale for not being able to swallow*

State B: PA criteria for baclofen oral solution, Fleqsuvy, and Lyvispah:

1. *Age*
2. *Diagnosis of dysphagia*

Seglentis & tramadol

Time frame: 10/1/2022 to 12/31/2022

Drug Name	Total Rx	Paid Amount	Paid/Rx	Avg Quantity/DS	Utilizers	Age Range
tramadol tab 50mg	1,157	$12,384.19	$10.70	#59/16 days	572	14 – 94
tramadol tab 100mg	6	$642.05	$107.01	#90/24 days	2	55, 62
tramadol tab 100mg ER	10	$486.57	$48.66	#33/24 days	3	38 – 61
tramadol tab 200mg ER	9	$557.09	$61.90	#27/27 days	3	35 – 48
tramadol tab 300mg ER	5	$334.17	$66.84	#30/30 days	2	41, 46
tramadol/APAP tab 37.5-325	2	$25.05	$12.53	#25/5 days	2	47, 59
CONZIP (tramadol SR biphasic cap)	0					
SYNAPRYN (tramadol susp)	0					
QDOLO (tramadol sol 5mg/ml)*	0					
SEGLENTIS 56-44mg (celecoxib/tramadol tab)	1	$399.53	$399.53	#90/34 days	1	37
celecoxib cap 50mg	7	$117.75	$16.82	#47/30 days	3	2 – 49
celecoxib cap 100mg	64	$1,000.54	$15.64	#53/28 days	38	11 – 63
celecoxib cap 200mg	312	$4,827.22	$15.47	#46/30 days	159	14 – 65

Red font denotes drug is on PA; *not rebateable manufacturer

Conzip, Synaprn, and tramadol ER (Ultram ER) PA criteria:

- 30-day trial of tramadol IR in the past 120 days

Seglentis Indication:

- **Pain, acute:** Management of acute pain in adults that is severe enough to require an opioid analgesic and for which alternative treatments are inadequate.

State A criteria for Seglentis:

1. *Prescriber must provide documentation that separate components are unsuitable for use*

State B: PA criteria for Seglentis:

1. *Inform provider of generic celecoxib and generic tramadol*
2. *Letter of medical necessity must be submitted stating the reasons generic celecoxib and generic tramadol as separate products are not appropriate for the member*

Health Plan: PA criteria for Seglentis:

1. *Step Therapy: Patient has tried and failed, or is intolerant to three other non-opioid analgesics (e.g., meloxicam, ibuprofen) in the last 120 days*

Vuity & pilocarpine drops

Time frame: 2Q2022 to 4Q2022

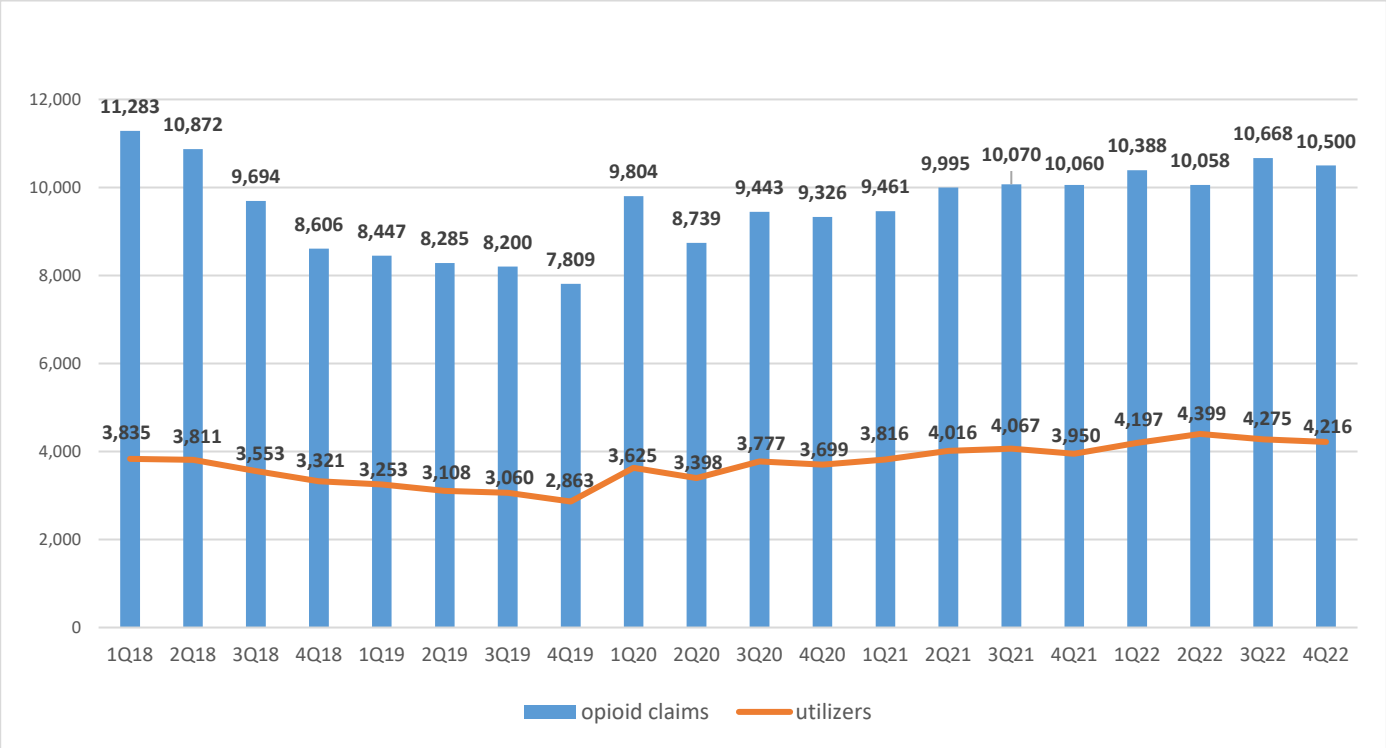
	2Q2022				3Q2022				4Q2022			
Drug Name	**Total Rx**	**Paid Amount**	**Paid/ Rx**	**Mbr**	**Total Rx**	**Paid Amount**	**Paid/ Rx**	**Mbr**	**Total Rx**	**Paid Amount**	**Paid/ Rx**	**Mbr**
VUITY sol 1.25%	11	$866.06	$78.73	7	13	$1,014	$77.98	6	10	$786.40	$78.64	5
pilocarpine sol 1%	0				1	$0	$0	1	0			
pilocarpine sol 2%	0				0				0			
pilocarpine sol 4%	0				0				0			

Indications:

- pilocarpine 1%, 2%, 4% solution
  - Reduction of elevated intraocular pressure (IOP) in patients with open-angle glaucoma or ocular hypertension
  - Induction of miosis
  - Prevention of postoperative elevated IOP associated with laser surgery

- Vuity 1.25% solution
  - Treatment of presbyopia in adults
  - $32.30 per ml (2.5ml per bottle) vs pilocarpine $5.00 per ml

Opioid Summary



- 1Q2018 to 4Q2019 excludes IHS
- 1Q2020 to current includes IHS
- March 13, 2020 – Pandemic Closure

Opioid Initiatives:

1. June 1, 2018 – early refill threshold for controlled substance changed from 75% to 85%
2. July 1, 2028 – PA for more than one LAO and one SAO
3. August 1, 2018 – opioid Naïve PA (initial 7-day supply and 60 MED limit)
4. October 1, 2018 to October 1, 2019 – decrease from 300 MED to 90 MED (cancer diagnosis excluded)

Other Initiatives:

- Buprenorphine PA (Bunavail/Suboxone/Zubsolv/Subutex)/ST (Belbuca/Butrans) removed 10/14/2019
- Lidoderm PA removed 8/1/2020

Total Eligibility and Utilizers

Quarter	Avg eligible members	Avg utilizing members of all drugs	% utilizing members of all drugs
1Q2020	123,573	27,089	21.9%
2Q2020	126,777	20,747	16.4%
3Q2020	132,373	23,417	17.7%
4Q2020	136,262	23,488	17.2%
1Q2021	139,748	24,405	17.5%
2Q2021	142,872	26,162	18.3%
3Q2021	146,023	27,847	19.1%
4Q2021	149,034	29,257	19.3%
1Q2022	151,735	28,892	19.0%
2Q2022	154,608	28,338	18.3%
3Q2022	157,627	29,109	18.5%
4Q2022	160,060	32,089	20.0%

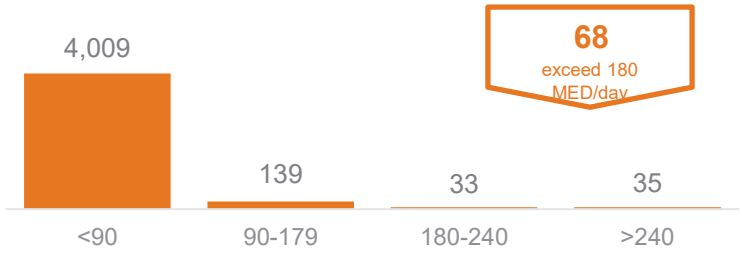
Opioid Utilization Snapshot

SDM 4Q2022
Sep 22 to Dec 22

Opioid Claims **10,500**
2.9% prescription claims filled for an opioid
0.9% higher than Medicaid FFS benchmark

Utilizers **4,216**
30.3% are high utilizers [1]
1.0% higher than high utilizers Medicaid FFS

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
50 opioid utilizing members with 3+ pharmacies

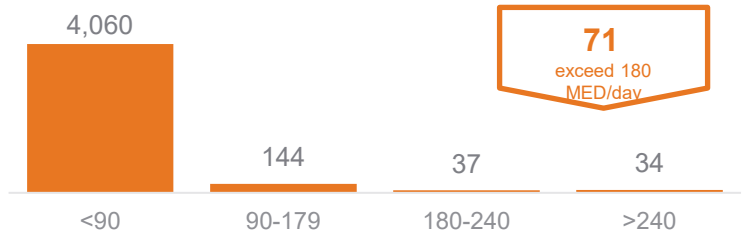
326 Shoppers: Poly Prescriber
opioid utilizing members with 3+ prescribers

3Q2022
Jun 22 to Sep 22

Opioid Claims **10,688**
3.1% prescription claims filled for an opioid
0.9% higher than Medicaid FFS benchmark

Utilizers **4,275**
30.1% are high utilizers [1]
0.5% higher than high utilizers Medicaid FFS

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
49 opioid utilizing members with 3+ pharmacies

357 Shoppers: Poly Prescriber
opioid utilizing members with 3+ prescribers

OPTUM Rx®

[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.

Opioid Utilization

SDM 4Q2022
Opportunities date range: Sep - Dec 2022
Benchmark: MEDICAID FEE FOR SERVICE

Utilizers: 4,216

2.9% of all Rx claims are filled for an Opioid

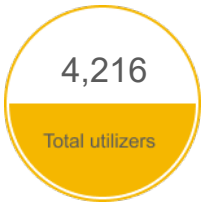
Opioid dependence can start in just a few days, and the risk of chronic opioid use increases with each additional day of opioid supplied, starting with the third day. Our Opioid Risk Management program, which includes point of sale, utilization management and retrospective drug utilization edits, are tightly aligned with CDC opioid prescribing guidelines which can help reduce exposure to excessive doses and prevent more members from transitioning from acute to chronic use.

- Opioid prescriptions account for 2.9% of all prescriptions this period, which is 0.9% higher than the benchmark
- 1,279 high opioid utilizers were identified this period, which is 0.1% higher than the benchmark

Opioid claims

PERCENT NON-COMPLIANT
9.5%

Opioid utilizers

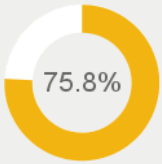


HIGH UTILIZERS
30.3%
1,279 high utilizers

0.1% over benchmark

High utilizers – view definition

Claim breakdown



short acting opioids

75.8% of all opioid Rxs were filled for short acting opioids. **1,898** Rxs were for medication assisted therapy (MAT) and **189** were for rescue therapy. CDC guidelines advise prescribers to manage pain with the lowest effective dose and to avoid or carefully justify doses for chronic users >90mg MME/day.

MAT – view definition
Overdose rescue therapy – view definition
MME – view definition

Utilizers by cumulative MED

68 utilizers exceed 180 MED/day

MED Scores	<90	90-179	180-240	>240
Utilizers	4,009	139	33	35

MED – view definition

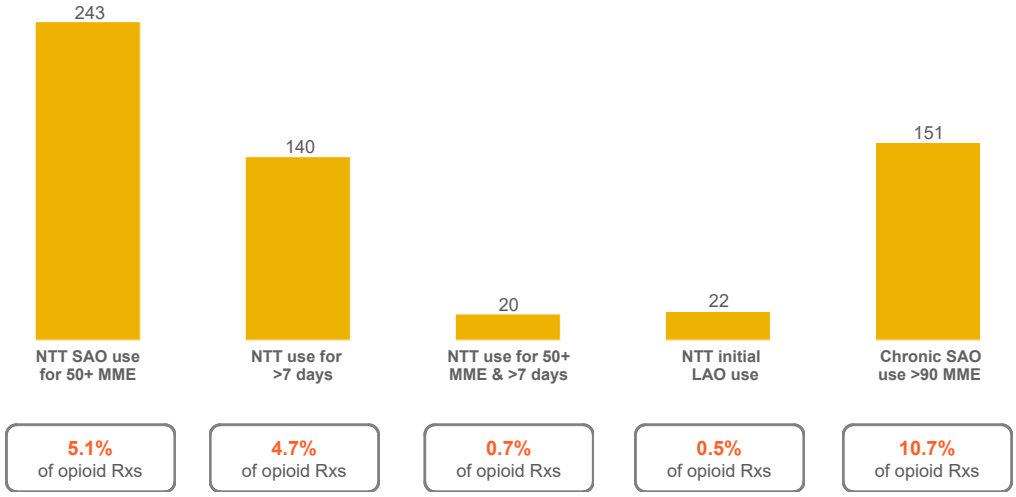
Opioid Opportunity Assessment

SDM 4Q2022
Opportunities date range: Sep - Dec 2022
Benchmark: MEDICAID FEE FOR SERVICE

Percent non-compliant: 9.5%

Utilizers non-compliant to opioid Rx CDC guidelines

(new to therapy and chronic use)



NTT - view definition | SAO - view definition | LAO - view definition | MME - view definition

DID YOU KNOW?

50 opioid utilizing members use 3 or more pharmacies and 326 opioid utilizing members use 3 or more prescribers.

Identification, management and prevention of fraudulent or potential abuse of opioid medications are monitored and addressed by OptumRx through various means in pharmacy network audit capabilities and high touch clinical programs that include care coordination with opioid prescribers.

Opioid utilizers with potentially contraindicated medication use

SKELETAL MUSCLE RELAXANTS	BENZODIAZEPINES	ANTICONVULSANTS	MEDICATION ASSISTED THERAPY	PRENATAL
734	543	738	N/A	124

Anticonvulsants –view definition

New Business

Dermatologic PA Review

- Adbry, Cibinqo, Opzelura – PA effective 7/1/2022

Opzelura PA Review

Time Frame: 7/1/2022 – 1/31/2023

Indication	Drug Class	Approved	Denied	Total	Mbr
Atopic Dermatitis	OPZELURA – PA effective 7/1/2022	2	9	11	7
	APPEALS	2	0	2	2

Opzelura Utilization

Time Frame: 1/1/2022 to 1/31/2023

	January 2022 to June 2022				July 2022 to January 2023				
Drug Name	Total Rx	Paid Amount	Paid/ Rx	Mbr	Total Rx	Paid Amount	Paid/ Rx	Mbr	Age Range
Opzelura cream 1.5% (ruxolitinib) avg qty 60gm/30 days	11	$21,546	$1,959	7	4	$7,588	$1,897	4	14 – 63
EUCRISA oint 2% (crisaborole) avg qty 80/28 days	125	$93,861	$751	87	107	$89,514	$837	74	0 – 57
pimecrolimus cream 1% avg qty 46gm/24 days	86	$18,987	$221	71	121	$21,601	$179	89	0 – 68
tacrolimus oint 0.03% avg qty 45gm/25 days	38	$3,701	$98	34	45	$2,834	$63	38	0 – 28
tacrolimus oint 0.1% avg qty 60gm/25 days	95	$12,826	$135	73	102	$10,731	$105	82	0 – 60

Red font denotes drug is on PA; Includes IHS (1 claim – pre-PA)

PA Criteria

1. Diagnosis of mild to moderate atopic dermatitis AND
2. Member is 12 years of age or older AND
3. One of the following:
   - Greater than or equal to 3% body surface area involvement
   - Involvement of sensitive body areas (e.g., face, hands, feet, scalp, groin)

AND

4. Greater than or equal to 90 days of topical drug therapy with **one** of the following: corticosteroids, pimecrolimus and/or tacrolimus, crisaborole AND
5. Member is not using concurrently with therapeutic biologics, other Janus kinase inhibitors, or potent immunosuppressants such as azathioprine or cyclosporine AND
6. Requested quantity does not exceed 240 g/30 days

Psoriasis & Atopic Dermatitis PA Review

Time Frame: 1/1/2022 – 12/31/2022

Indication	PA REVIEW	Approvals	Denials	Total	Utilizer
Psoriasis & other indications	CIMZIA/STARTER KIT	9	1	10	8
	COSENTYX/SENSOREADY PEN	20	0	20	19
	ENBREL/MINI/SURECLICK	27	2	29	27
	HUMIRA/PEN/STARTER PACK	108	29	137	111
	SKYRIZI/PEN	12	1	13	12
	OTEZLA	7	5	12	12
	SIMPONI	4	1	5	4
	STELARA	37	12	49	40
	TALTZ	14	1	15	14
	TREMFYA	9	0	9	9
Atopic Dermatitis & other indications	DUPIXENT	108	23	131	117
	RINVOQ	4	0	4	4
	ELIDEL (DAW PA)	0	1	1	1

Indication	APPEALS	Approvals	Denials	Total
Psoriasis, Atopic Dermatitis & other indications	DUPIXENT	11	1	12
	ENBREL SURECLICK	0	1	1
	HUMIRA PEN/STARTER	1	1	2
	OTEZLA	2	1	3
	STELARA	8	1	9

Utilization

Time Frame: 1/1/2022 to 12/31/2022

PA	Drug Name	Total Rx	Paid Amount	Paid/Rx	Utilizers	Avg Qty	Age Range
Psoriasis & other indications	CIMZIA (certolizumab pegol)	65	$321,956	$4,953	10	~1	22 – 50
	COSENTYX (secukinumab)	199	$1,309,209	$6,579	24	~2	6 – 61
	ENBREL (etanercept)	191	$1,149,238	$6,017	29	~3.8	6 – 64
	HUMIRA (adalimumab)	607	$5,161,909	$8,504	97	~2.6	7 – 64
	ILYUMYA (tildrakizumab-asmn)	0					
	OTEZLA tab (apremilast)	58	$222,463	$3,836	9	~59	23 – 61
	SILIQ (brodalumab)	0					
	SIMPONI (golimumab)	39	$212,575	$5,451	5	0.5	27 – 63
	SKYRIZI (risankizumab-rzaa)	43	$780,765	$18,157	11	1	20 – 60
	STELARA (ustekinumab)	167	$3,725,045	$22,306	37	1	10 – 63
	TALTZ (ixekizumab)	119	$898,896	$7,554	16	~1.2	15 – 57
	TREMFYA (guselkumab)	45	$563,579	$12,524	8	1	21 – 55
	VTAMA cream 1% (tapinarof)	3	$3,997	$1,332	2	60	21, 50
Atopic Dermatitis & other indications*	ADBRY (tralokinumab-ldrm)	0					
	CIBINQO tab (abrocitinib)	0					
	DUPIXENT (dupilumab)*	818	$2,695,984	$3,296	125	~3.6	0 – 62
	RINVOQ tab (upadacitinib)*	25	$137,131	$5,485	5	30	40 – 53

Red font denotes drug is on PA; Excludes IHS

Rosacea & Topical Acne PA Review

- Rosacea – PA effective 2/1/2020

Time Frame: 1/1/2022 to 12/31/2022

Indication	Drug Name	Approvals	Denials	Total	Utilizer
Rosacea	azelaic acid 15% gel	13	1	14	13
	ivermectin cream (Soolantra)	1	17	18	14
	MIRAVASO	1	0	1	1
Topical Acne	ACZONE (dapsone)	6	7	13	13
	adapalene	17	30	47	43
	adapalene-benzoyl peroxide	6	17	23	17
	ARAZLO (tazarotene)	1	0	1	1
	AZELEX 20% cream (azelaic acid)	3	1	4	4
	clindamycin-tretinoin	0	4	4	4
	EPIDUO/EPIDUO FORTE	2	0	2	2
	TAZORAC/tazarotene	5	10	15	12

Indication	APPEALS	Approvals	Denials	Total
Rosacea & Topical Acne	adapalene-benzoyl peroxide	1	0	1
	ivermectin cream (Soolantra)	1	0	1

Rosacea Utilization

Time Frame: 1/1/2022 to 12/31/2022

PA	Drug Name	Total Rx	Paid Amount	Paid/Rx	Utilizers	Avg Qty	Age Range
Rosacea	azelaic gel 15%	27	$1,687	$62.45	18	50	12 – 49
	AZELEX cream 20% (azelaic)	6	$3,931	$655.02	3	43.3	30 – 44
	FINACEA AER 15% (azelaic)	9	$3,533	$392.52	3	50	19 – 48
	MIRAVASO gel (brimonidine)	4	$2,220	$550.03	1	30	42
	ivermectin cream 1%	15	$4,028	$268.51	5	45	22 – 51
	metronidazole cream 0.75%	50	$2,145	$42.89	41	45	14 – 20
	metronidazole lotion 0.75%	5	$672	$134.40	4	59	6 – 33
	metronidazole gel 0.75%	54	$1,807	$33.46	44	45	0 – 63
	metronidazole gel 1%	22	$1,639	$75.50	11	60	12 – 61
	RHOFADE cream 1% (oxymetazoline)	8	$4,428	$553.14	2	30	29 – 49

Red font denotes drug is on PA; Excludes IHS

Rosacea ST Criteria

Trial of a generic topical acne agent (benzoyl peroxide, clindamycin phosphate, erythromycin, sulfacetamide sodium/sulfur, sulfacetamide sodium, tretinoin, metronidazole cream/gel/lotion 0.75%) in the past 120 days.

Topical Acne Utilization

Time Frame: 1/1/2022 to 12/31/2022

PA	Drug Name	Total Rx	Paid Amount	Paid/Rx	Utilizer	Avg Qty	Age Range
Topical Acne	adapalene cream 0.1%	17	$2,644.17	$155.54	10	45	14 – 20
	AKLIEF cream (trifarotene)	3	$1,294.92	$431.64	2	45	12 – 19
	AMZEEQ AER (minocycline micronized)	10	$2,301.38	$230.14	4	30	12 – 19
	DIFFERIN cream 0.1%	1	$125.23	$125.23	1	45	13
	adapalene gel 0.1%	6	$700.23	$116.71	6	45	14 – 19
	DIFFERIN gel 0.1%	2	$63.10	$31.55	1	45	14
	adapalene gel 0.3%	41	$2,618.97	$63.88	25	45	19 – 27
	adapalene-benzoyl gel 0.1-2.5%	27	$1,114.98	$41.30	13	45	9 – 60
	adapalene-benzoyl gel 0.3-2.5%	15	$6,140.42	$409.36	10	45	12 – 26
	EPIDUO FORTE gel 0.3-2.5%	6	$2,499.58	$416.60	1	45	15
	benzoyl peroxide gel 2.5%, 5%, 10% *(OTC covered for foster care)*	24	$354.58	$14.78	16	~48	11 – 20
	benzoyl peroxide wash *(OTC covered for foster care)*	15	$246.83	$16.45	7	~202	14 – 19
	benzoyl-erythromycin gel 3-5%	101	$5,479.17	$54.25	42	~41	11 – 52
	clindamycin lotion, aerosol, gel	2,418	$96,075.29	$39.74	1,155	~57	0– 63
	clindamycin-benzoyl peroxide gel	160	$7,482.91	$46.77	79	~44	10 – 48
	ONEXTON gel (clindamycin-benzoyl)	1	$648.07	$648.07	1	50	12
	dapsone gel 5% or 7.5%	42	$12,036.67	$286.59	22	~69	14 – 39
	erythromycin gel & solution 2%	71	$3,019.02	$42.52	43	~52	0 – 53
	sulfacetamide cream 10-5%	1	$216.39	$216.39	1	57	44
	sulfacetamide liquid 10-5%	2	$106.88	$53.44	2	~284	30, 43
	sulfacetamide lotion 10%	9	$802.31	$89.15	3	118	15 – 44
	sulfacetamide wash	5	$1,953.15	$390.63	2	473	27, 30
	tretinoin cream	1,537	$121,560.38	$79.09	836	~38	0 – 63
	tretinoin gel 0.1%	226	$25,771.50	$114.03	110	~34	6 – 57
	tretinoin microsphere gel/pump	22	$9,527.49	$433.07	7	~44	14 – 55
	RETIN-A cream 0.05%	2	$195.16	$97.58	2	45	18, 20
	RETIN-A MICRO gel 0.08%	2	$189.72	$94.86	1	45	39
	TWYNEO cream 1-3% (tretinoin-benzoyl)	2	$871.10	$435.55	2	30	12, 16
	tazarotene cream	28	$3,159.74	$112.85	8	~38	5 – 60
	TAZORAC cream 0.05%	1	$454.49	$454.49	1	30	17
	tazarotene gel	1	$849.07	$849.07	1	60	22
	TAZORAC gel 0.1%	1	$482.19	$482.19	1	30	24
	ARAZLO lotion 0.045% (tazarotene)	2	$929.00	$464.50	2	45	12, 18
	WINLEVI cream 1% (clascoterone)	35	$18,857.64	$538.79	23	60	11 – 46

Red font denotes drug is on PA; Excludes IHS

Topical Acne ST Criteria

Trial of a generic topical acne agent (benzoyl peroxide, clindamycin phosphate, erythromycin, metronidazole cream/gel/lotion sulfacetamide sodium/sulfur, sulfacetamide sodium, tretinoin) in the past 120 days

TAZORAC (tazarotene) Criteria

Patient has diagnosis of plaque psoriasis

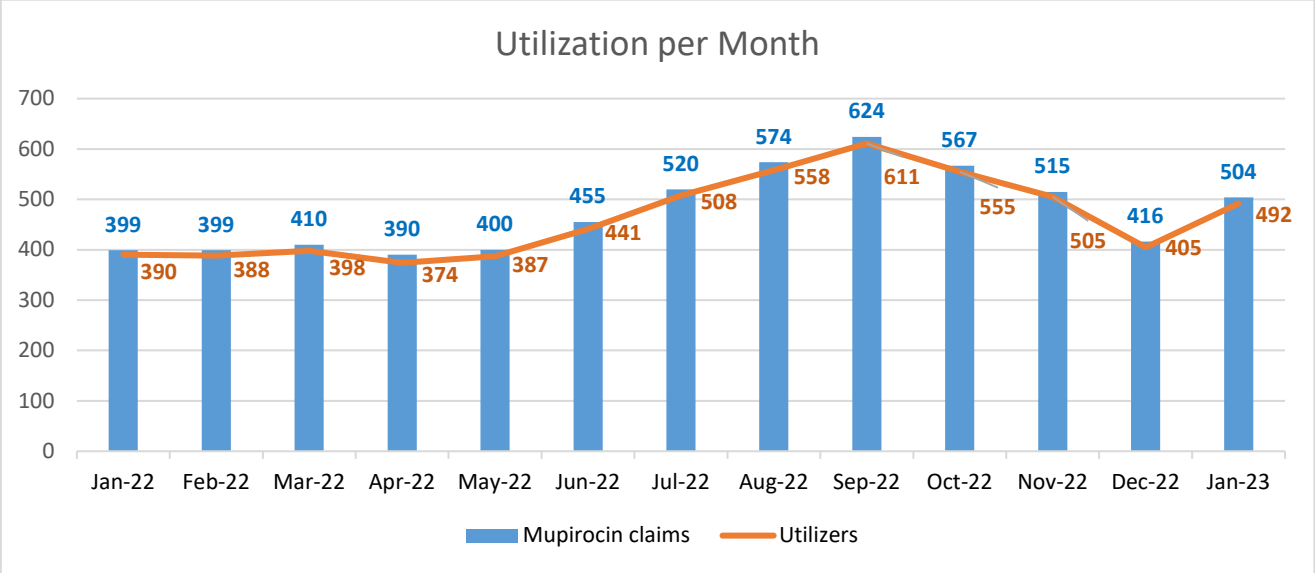
Mupirocin Trend

Time Frame: 1/1/2022 to 1/31/2023

	2Q2022				3Q2022				4Q2022			
Drug Name	**Total Rx**	**Paid Amount**	**Paid/ Rx**	**Mbr**	**Total Rx**	**Paid Amount**	**Paid/ Rx**	**Mbr**	**Total Rx**	**Paid Amount**	**Paid/ Rx**	**Mbr**
mupirocin cream 2% avg qty 23gm/14 days	18	$1,959	$130	18	27	$3,313	$123	25	23	$1,832	$84	23
mupirocin oint 2% avg qty 23gm/12 days	981	$14,162	~$15	887	1,231	$17,576	~$15	1,148	1,043	$15,034	~$15	960

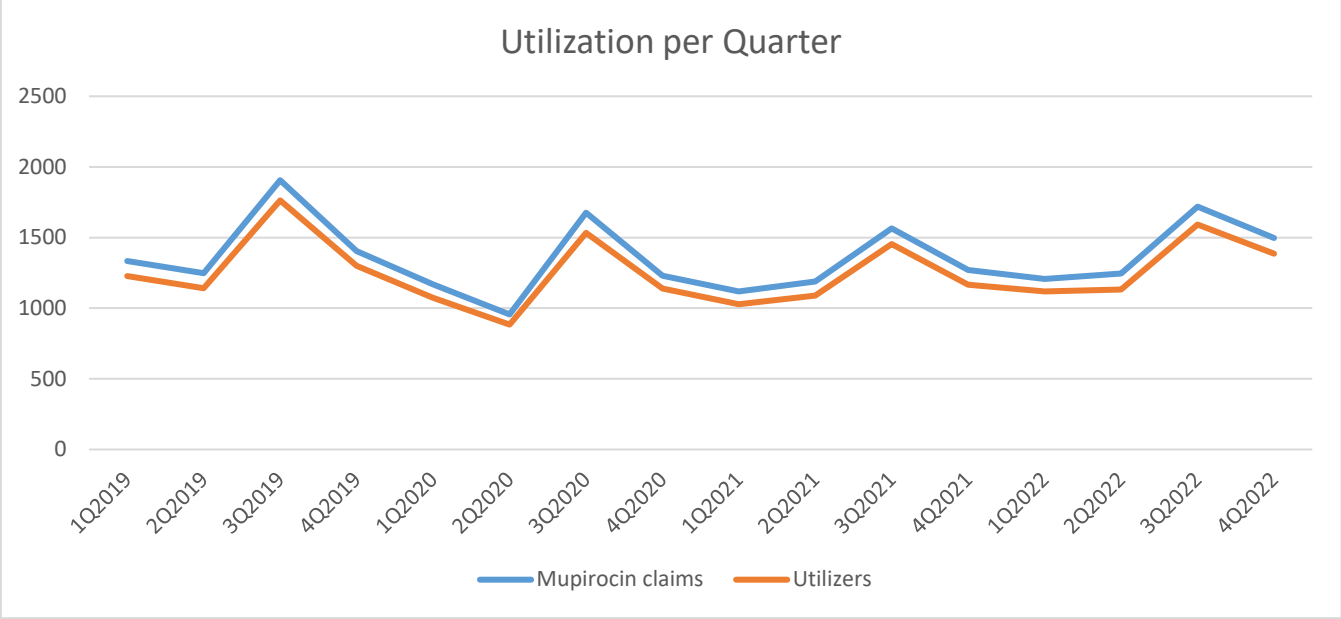
Excludes IHS

Time Frame: 1/1/2022 to 1/31/2023



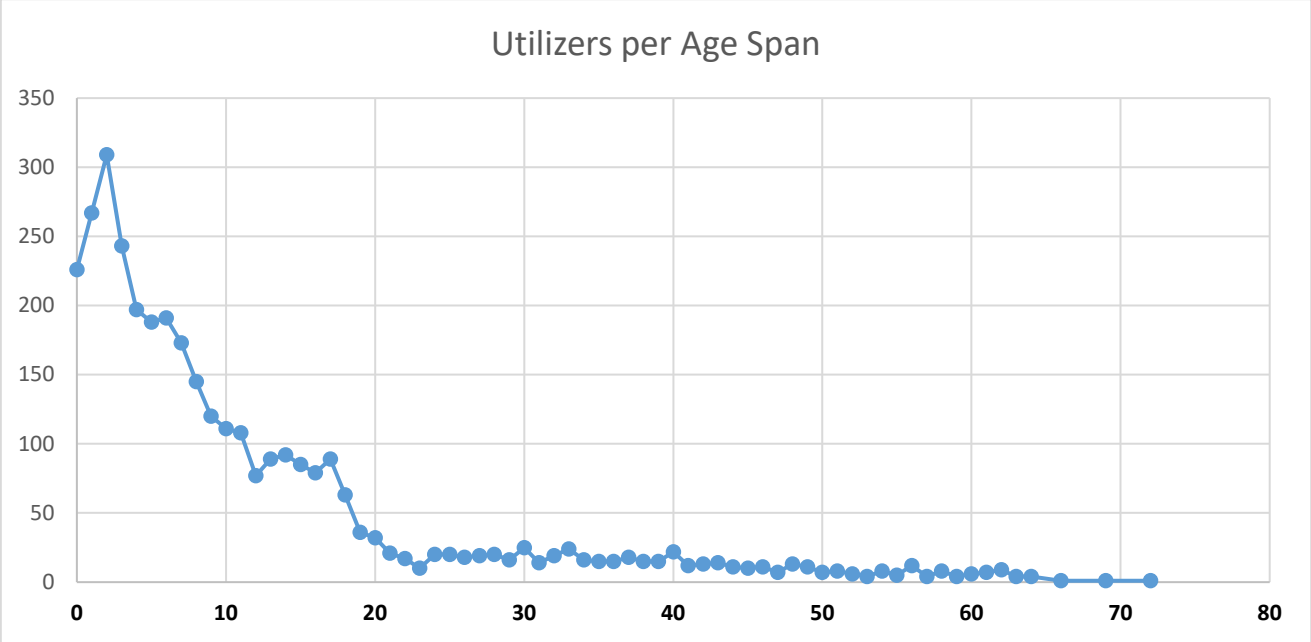
-Includes IHS

Time Frame: Year 2019 to 2022



Includes IHS

Time Frame: 1/1/2022 to 12/31/2022



Includes IHS; Age in years on X-axis; Utilizers on Y-axis

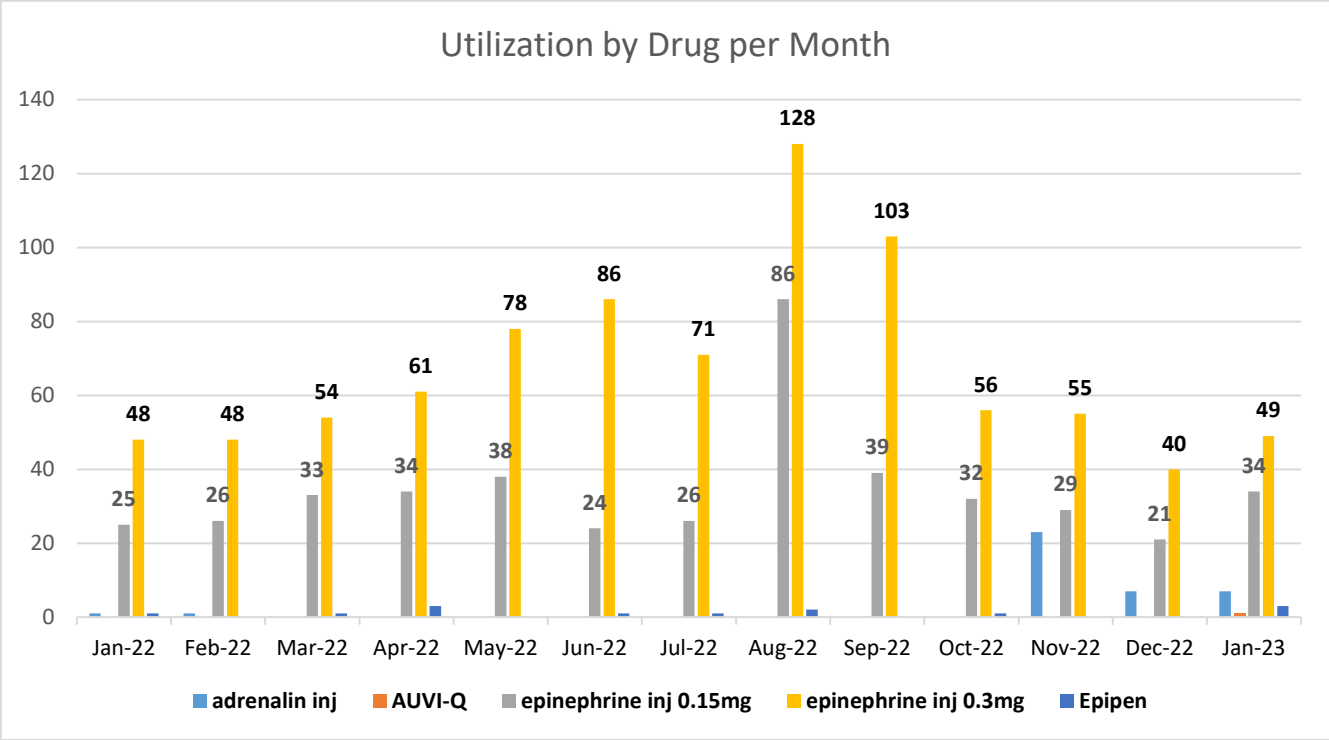
Epinephrine Trend

Time Frame: 1/1/2022 to 12/31/2022

	2Q2022				3Q2022				4Q2022			
Drug Name	**Total Rx**	**Paid Amount**	**Paid/ Rx**	**Mbr**	**Total Rx**	**Paid Amount**	**Paid/ Rx**	**Mbr**	**Total Rx**	**Paid Amount**	**Paid/ Rx**	**Mbr**
adrenalin 1mg/ml	0				0				30	$765.30	$25.51	29
adrenalin 30mg/30ml	0				0				0			
AUVI-Q 0.1mg	0				0				0			
epinephrine 0.15mg	90	$27,125	$307	86	143	$41,567	$306	136	77	$22,343	$290	72
epinephrine 0.3mg	200	$60,360	$302	186	253	$71,985	$285	232	129	$36,791	$285	125
EPIPEN-JR 0.15mg	0				1	$294	$294	1	0			
EPIPEN 2-pak 0.3mg	0				1	$294	$294	1	0			

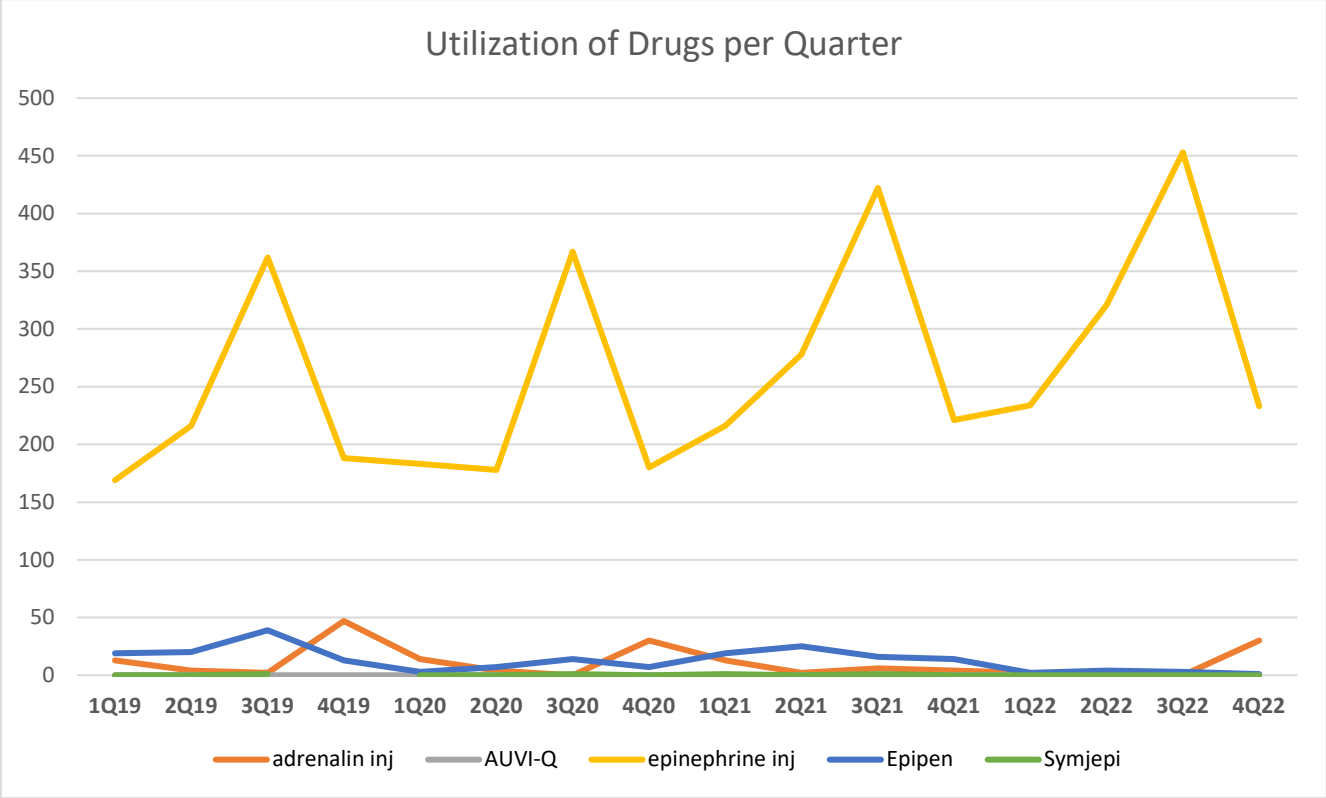
Excludes IHS

Time Frame: 1/1/2022 to 1/31/2023



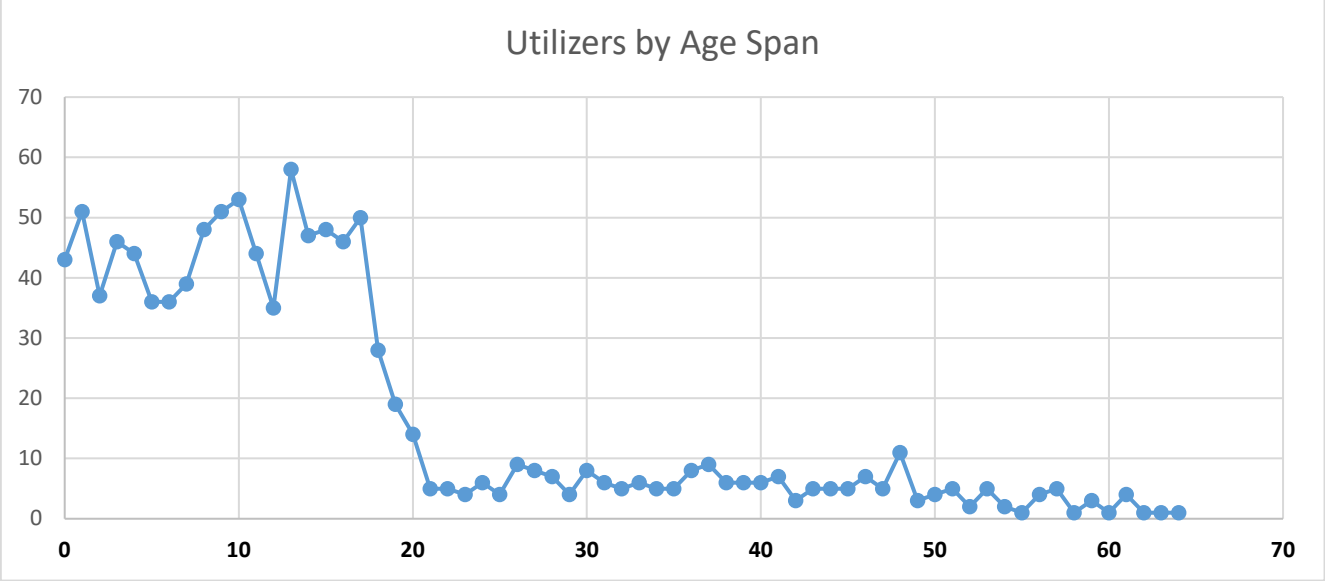
Includes IHS

Time Frame: Year 2019 to 2022



Includes IHS

Time Frame: 1/1/2022 to 1/31/2023



Includes IHS; Age in years on X-axis; Utilizers on Y-axis

Table of Contents

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

Prior Authorization Request Form

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

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

Clinical Information (required)

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

ICD-10 Code(s): _____

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

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

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

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

_____

_____

_____

_____

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South Dakota Department of Social Services

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Mon-Sat: 7am to 7pm Central

Quantity Limit Request Form

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

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

Clinical Information (required)

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

ICD-10 Code(s): _____

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

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

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

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South Dakota Department of Social Services

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

High Dollar/Claim Dollar Amount Override Prior Authorization Request Form

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

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

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

Clinical Information (required)

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

ICD-10 Code(s): _____

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

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

_____

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South Dakota Department of Social Services

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

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)

Select the diagnosis below:

- ❑ Acne vulgaris
- ❑ Plaque psoriasis **[Tazorac (tazarotene) only]**
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

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.
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South Dakota Department of Social Services

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

Topical Rosacea 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:

❑ Acne rosacea

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

Medication history:

Has the patient had a trial of a generic topical acne agent (benzoyl peroxide, clindamycin phosphate, erythromycin, sulfacetamide sodium/sulfur, sulfacetamide sodium, tretinoin, metronidazole cream/gel/lotion) in the past 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.
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South Dakota Department of Social Services

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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.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

Antidepressants Prior Authorization Request Form

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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.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

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.
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This form may be used for non-urgent requests and faxed to 1-844-403-1029.

South Dakota Department of Social Services

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

Bonjesta® 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): _____

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.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

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**

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.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

Brexafemme® 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:

❑ Vulvovaginal candidiasis

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

Clinical information:

Has the patient tried and failed 3 trials of fluconazole or clotrimazole in the past 14 days? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes

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

❑ Requested strength/dose is not commercially available

❑ Other:

_____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
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This form may be used for non-urgent requests and faxed to 1-844-403-1029.

South Dakota Department of Social Services

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

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.
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This form may be used for non-urgent requests and faxed to 1-844-403-1029.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

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**

South Dakota Department of Social Services

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

Desoxyn® (methamphetamine) Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ Attention Deficit Disorder with Hyperactivity

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

Medication history:

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

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

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.

South Dakota Department of Social Services

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

Dificid® Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

❑ Clostridium difficile-associated diarrhea (CDAD)

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

Clinical information:

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

Select the following that the patient has failed:

❑ Initial episode (mild to moderate severity) – metronidazole

❑ Initial episode (severe) – vancomycin

❑ Initial episode (severe, complicated) – vancomycin and metronidazole

❑ First recurrence – same regimen as first episode

❑ Second recurrence – oral vancomycin in tapered regimen

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.

South Dakota Department of Social Services

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

Durlaza™ Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

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

Clinical information:

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

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

_____

_____

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.

South Dakota Department of Social Services

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

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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This form may be used for non-urgent requests and faxed to 1-844-403-1029.

South Dakota Department of Social Services

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

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, list ICD-10 Code(s): _____
- ❑ Seizures associated with Lennox-Gastaut syndrome, list (LGS) ICD-10 Code(s): _____
- ❑ Seizures associated with Tuberous Sclerosis Complex (TSC), list ICD-10 Code(s): _____
- ❑ Refractory epilepsy, list ICD-10 Code(s): _____
- ❑ 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?

_____

_____

_____

_____

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South Dakota Department of Social Services

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

❑ Spinal muscular atrophy (SMA): Type _____

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

Clinical information:

1. Select if the requested medication is prescribed by or in consultation with one of the following specialists:
   - ❑ Neurologist with expertise in the diagnosis and treatment of SMA
   - ❑ Other _____
2. How many SMN2 copies? _____
3. Does the mutation or deletion of genes in chromosomes 5q result in the following:
   - ❑ Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13) _____
   - ❑ Compound heterozygous mutation (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2]) _____
   - ❑ Other _____
4. Is the patient dependent on invasive ventilation or tracheostomy? ❑ **Yes** ❑ **No**
5. Is the patient dependent on use of non-invasive ventilation beyond use for naps and nighttime sleep? ❑ **Yes** ❑ **No**
6. Has one of the other exams listed below (based on patient's age and motor ability) been conducted to establish baseline motor ability by a board-certified neurologist?
   - ❑ Hammersmith Functional Motor Scale Expanded (HFMSE)
   - ❑ Hammersmith Infant Neurological Exam (HINE) (infant to early childhood)
   - ❑ Upper Limb Module (ULM) Test (Non ambulatory)
   - ❑ Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)
   - ❑ Motor Function Measure 32 (MFM-32) Scale
7. Is the patient on concomitant chronic survival motor neuron (SMN) modifying therapy for the treatment of SMA (e.g., Spinraza)?
   ❑ **Yes** ❑ **No**
8. Has the patient previously received gene replacement therapy for the treatment of SMN (e.g., Zolgensma)? ❑ **Yes** ❑ **No**

South Dakota Department of Social Services

Evrysdi™ Prior Authorization Request Form (Page 2 of 3)

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9. If patient has previously received gene therapy for the treatment of SMA (e.g., Zolgensma), provider to attests that there has been an inadequate response to gene therapy (e.g., sustained decrease in at least one motor test score over a period of 6 months) or worsening in clinical status since receiving gene therapy as demonstrated by a decline of minimally clinical important difference fro highest score achieved on one of the following exams:
   - ❑ HFMSE: decline of at least _____ points on kicking and _____ points on any other milestones (excluding voluntary grasp)
   - ❑ HINE-2: decline of at least _____ points
   - ❑ CHOP INTEND: decline of at least _____ points

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: _____

Reauthorization:

If this is a reauthorization request, answer the following:

1. Provide documentation of positive clinical response to therapy (e.g., chart notes, laboratory values) from pretreatment baseline status as demonstrated by the most recent results (less than 1 month prior to reauthorization request) from one of the following exams:
   - ❑ One of the following HINE-2 milestones _____
     - ❑ Improvement or maintenance of previous improvement of at least a 2-point (or maximal score) increase in ability to kick
     - ❑ Improvement or maintenance of previous improvement of at least a 1-point increase in any other HINE-2 milestone (e.g., head control, rolling, sitting, crawling, etc.), excluding voluntary grasp
     - ❑ Patient exhibited improvement, or maintenance of previous improvement in more HINE motor milestones than worsening, from pretreatment baseline (net positive improvement)
     - ❑ Patient has achieved and maintained any new motor milestones when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk)
   - ❑ One of the following HFMSE milestones _____
     - ❑ Improvement or maintenance of a previous improvement of at least a 3-point increase in score from pretreatment baseline
     - ❑ Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk)
   - ❑ One of the following ULM test milestones _____
     - ❑ Improvement or maintenance of a previous improvement of at least a 2-point increase in score from pretreatment baseline
     - ❑ Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk)
   - ❑ One of the following CHOP-INTEND milestones _____
     - ❑ Improvement or maintenance of a previous improvement of at least a 4-point increase in score from pretreatment baseline
     - ❑ Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk)
   - ❑ One of the following MFM-32 milestones _____
     - ❑ Improvement or maintenance of a previous improvement of at least a 3-point increase in score from pretreatment baseline
     - ❑ Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk)
2. Is the patient dependent on invasive ventilation or tracheostomy? ❑ **Yes** ❑ **No**
3. Is the patient dependent on the use of non-invasive ventilation beyond use for naps and nighttime sleep? ❑ **Yes** ❑ **No**

South Dakota Department of Social Services

Evrysdi™ Prior Authorization Request Form (Page 3 of 3)

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4. Is the requested medication prescribed by or in consultation with a neurologist with expertise in the diagnosis and treatment of SMA?
   ❑ **Yes** ❑ **No**

5. Is the patient is receiving concomitant chronic survival motor neuron (SMN) modifying therapy for the treatment of SMA (e.g., Spinraza)? ❑ **Yes** ❑ **No**

6. Has the patient previously received gene replacement therapy for the treatment of SMA (e.g., Zolgensma)? ❑ **Yes** ❑ **No**

7. Was there inadequate response to gene therapy (e.g., sustained decrease in at least one motor test score over a period of 6 months)? If so, submit medical records (e.g., chart notes) documenting the inadequate response to gene therapy.

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.

South Dakota Department of Social Services

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

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, oxybutynin ER, darifenacin ER, fesoterodine ER, solifenacin, tolterodine, tolterodine ER, trospium, or trospium ER ? ❑ **Yes** ❑ **No**

List drug(s) tried_____

For Gelnique, Myrbetriq suspension, Oxytrol, or Vesicare LS 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.

South Dakota Department of Social Services

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

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.
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South Dakota Department of Social Services

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

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?

_____

_____

_____

_____

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This form may be used for non-urgent requests and faxed to 1-844-403-1029.

South Dakota Department of Social Services

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

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's 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**

South Dakota Department of Social Services

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 gestational age (SGA), also answer the following:

Did the patient have post-natal growth failure at one year? ❑ **Yes** ❑ **No**

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**

South Dakota Department of Social Services

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?

_____

_____

_____

_____

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South Dakota Department of Social Services

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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.

South Dakota Department of Social Services

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

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?

_____

_____

_____

_____

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South Dakota Department of Social Services

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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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South Dakota Department of Social Services

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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?

_____

_____

_____

_____

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South Dakota Department of Social Services

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

Hepatitis C 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:

❑ Hepatitis C virus infection

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

Clinical information:

Document the patient's genotype: _____

Document the patient's weight: _____Kg

Patient must have one of the following (providers may be asked to provide documenatation):

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

Does the patient have compensated liver disease (Child-Pugh A)? ❑ **Yes** ❑ **No**

Does the patient have decompensated liver disease (Child-Pugh B or C)? ❑ **Yes** ❑ **No**

Is the patient treatment naïve? ❑ **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 Epclusa or generic sofosbuvir/velpatasvir, also answer the following:

Is the patient ineligible or has an intoleterance to ribavirin? ❑ **Yes** ❑ **No**

Has the patient had prioir treatment failure with sofosbuvir or NS5A-based treatment? ❑ **Yes** ❑ **No**

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

Is the patient taking anticancers (e.g., topotecan)? ❑ **Yes** ❑ **No**

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

For Harvoni or generic ledipasvir/sofosbuvir, also answer the following:

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

- ❑ Anticonvulsants (e.g., carbamazepine, oxcarbazepine, phenobarbital, phenytoin)
- ❑ P-glycoprotein (P-gp) inducers (e.g., rifampin, St. John's wort)
- ❑ HIV antiretrovirals (e.g., tipranavir/ritonavir)
- ❑ Tenofovir-containing HIV regimens
- ❑ Anticaners (e.g., topotecan)

For Mavyret (glecaprevir-pibrentasvir), also answer the following:

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)

South Dakota Department of Social Services

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

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

For Sovaldi (sofosbuvir), also answer the following:

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

- ❑ Pegylated interferon and ribavirin
- ❑ Ribavirin

Does the patient have severe renal impairment (eGFR < 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 Vosevi (sofosbuvir-velpatasvir-voxilaprevir), 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 (elbasvir-grazoprevir), 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? ❑ **Yes** ❑ **No**

Has the patient failed the 2-drug regimen of peginterferon alfa and ribavirin? ❑ **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.
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This form may be used for non-urgent requests and faxed to 1-844-403-1029.

South Dakota Department of Social Services

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

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: _____

South Dakota Department of Social Services

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

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: _____

_____

_____

South Dakota Department of Social Services

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

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.
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This form may be used for non-urgent requests and faxed to 1-844-403-1029.

South Dakota Department of Social Services

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

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.
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South Dakota Department of Social Services

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Mon-Sat: 7am to 7pm Central

Long Acting and Short Acting Opioid Prior Authorization Request Form

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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.
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South Dakota Department of Social Services

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Mon-Sat: 7am to 7pm Central

Esbriet® & Ofev® Prior Authorization Request Form

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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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South Dakota Department of Social Services

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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)
- ❑ Systemic sclerosis-associated interstitial lung disease
- ❑ 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
- ❑ Other _____

Will Actemra be used in combination with another biologic agent or targeted immunomodulator? ❑ **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**

South Dakota Department of Social Services

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

Adbry® Prior Authorization Request Form

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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 (describe severity level)_____

❑ 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 ❑ Allergist/Immunologist ❑ Other _____

Medication history:

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

Has the patient have a documented 14-day trial of a topical corticosteroid, pimecrolimus cream, tacrolimus ointment, or Eurisa (crisaborole)? _____

_____

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.

South Dakota Department of Social Services

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

Cibinqo™ Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Atopic dermatitis (describe severity level)_____

❑ 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 ❑ Allergist/Immunologist ❑ Other _____

Medication history:

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

Has the patient have a documented 14-day trial of a topical corticosteroid, pimecrolimus cream, tacrolimus ointment, or Eurisa (crisaborole)? _____

_____

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.

South Dakota Department of Social Services

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

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)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
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
- ❑ Active non-radiographic axial spondyloarthritis
- ❑ 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 ❑ Other _____

Will the requested medication be used in combination with another biologic agent or targeted immunomodulator? ❑ **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**

For active non-radiographic axial spondyloarthritis, 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**

South Dakota Department of Social Services

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.

South Dakota Department of Social Services

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

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
- ❑ Active Non-radiographic axial spondyloarthritis
- ❑ Active enthesitis-related 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 ❑ Rheumatologist ❑ Other _____

Will the requested medication be used in combination with another biologic agent or targeted immunomodulator? ❑ **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**

For active non-radiographic axial spondyloarthritis or enthesitis-related arthritis, 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**

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.

South Dakota Department of Social Services

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

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
- ❑ Eosinophilic esophagitis
- ❑ Prurigo nodularis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Atopic dermatitis:

Has the patient had a documented trial of a topical corticosteroid, pimecrolimus cream, tacrolimus ointment, Eurisa (crisaborole) 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 gastroenterologist? ❑ **Yes** ❑ **No**

South Dakota Department of Social Services

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

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

Eosinophilic esophagitis:

Has the patient had a documented trial of a high-dose proton pump inhibitor for at least 8 weeks or swallowed topical steroid (e.g., fluticasone propionate or oral budesonide suspension)? ❑ **Yes** ❑ **No**

Was Dupixent prescribed by or in consultation with an allergist/immunologist, pulmonologist, or otolaryngologist?

❑ **Yes** ❑ **No**

Prurigo nodularis

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

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

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

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.

South Dakota Department of Social Services

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

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 or targeted immunomodulator? ❑ **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**

South Dakota Department of Social Services

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?

_____

_____

_____

_____

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.

South Dakota Department of Social Services

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

Enspryng® 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:

❑ Neuromyelitis optical disorder (NMOSD)

❑ 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:

❑ Neurologist ❑ Other _____

Will the requested medication be used in combination with another biologic agent? ❑ **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.

South Dakota Department of Social Services

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

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?

_____

_____

_____

_____

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.

South Dakota Department of Social Services

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

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 or targeted immunomodulator? ❑ **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**

South Dakota Department of Social Services

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?

_____

_____

_____

_____

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.

South Dakota Department of Social Services

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

Amjevita™ 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
- ❑ 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
- ❑ 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 or targeted immunomodulator? ❑ **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 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 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**

South Dakota Department of Social Services

Amjevita™ Prior Authorization Request Form (Page 2 of 2)

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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**

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.

South Dakota Department of Social Services

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

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)]
- ❑ Tumor necrosis factor receptor associated periodic syndrome or hyperimmunoglobulin D syndrome (HIDS)/mevalonate kinase deficiency (MKD) or familial mediterranean fever
- ❑ Still's disease
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Select if the requested medication is diagnosed by, or upon consultation with or recommendation of the following specialists:
❑ Allergist/Immunologist ❑ Dermatologist ❑ Neurologist ❑ Rheumatologist ❑ Other _____

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

For active systemic juvenile idiopathic arthritis or Still's disease, 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**

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.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

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)
- ❑ Deficiency of interleukin-1 receptor antagonist (DIRA)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

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

Will the requested medication be used in combination with another biologic agent? ❑ **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: _____

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.

South Dakota Department of Social Services

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

Nucala® Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

- ❑ Severe asthma with an eosinophilic phenotype
- ❑ Eosinophilic granulomatosis with polyangiitis (Churg-Strauss Syndrome)
- ❑ Hypereosinophilic syndrome
- ❑ Chronic rhinosinusitis with nasal polys (CRSwNP)
- ❑ 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**

For chronic rhinosinusitis with nasal polyps (CRSwNP), also answer the following:

Has the patient experienced inadequate response to nasal corticosteroids? ❑ **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.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

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: _____

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

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)
- ❑ Moderately to severely active ulcerative colitis
- ❑ Active psoriatic arthritis
- ❑ Active ankylosing spondylitis
- ❑ Active atopic dermatitis
- ❑ 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 ❑ Other _____

Will Rinvoq be used in combination with another biologic agent, Janus Kinus inhibitor e.g., Olumiant, Dupixent, Xeljanx/XR), or other potent immunsuppressants (e.g., azathioprine, cyclosporine, methotrexate, mycophenolate, etc)? ❑ **Yes** ❑ **No**

For rheumatoid arthritis, psoriatic arthritis, ulcerative colitis, and ankylosing spondylitis also answer the following:

Has the patient had an inadequate response to, intolerance to, or contraindication to one or more TNF blockers (e.g., Cimzia, Enbrel, Humira, Simponi, Remicade, etc)? _____

For atopic dermatitis also answer the following:

Has the patient had an inadequate response to, intolerance to, or contraindication to one or more systemic drug product for the treatment of atopic dermatitis (e.g., Adbry, Dupixent, etc)? _____

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.

South Dakota Department of Social Services

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

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?

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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.

South Dakota Department of Social Services

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

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: _____

South Dakota Department of Social Services

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

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
- ❑ Active psoriatic arthritis
- ❑ 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 ❑ Other _____

Will the requested medication 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 (list)_____

_____

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.

South Dakota Department of Social Services

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

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
- ❑ 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 (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, calcipotriene, cyclosporine, acitretin, sulfasalazine, tazarotene, corticosteroid)? ❑ **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 conventional therapy (e.g., azathioprine, mercaptopurine, methotrexate, corticosteroids)? ❑ **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 one or more conventional therapy (e.g., corticosteroids, mesalamine, balsalazide, olsalazine, azathioprine, mercaptopurine, methotrexate)? ❑ **Yes** ❑ **No**

South Dakota Department of Social Services

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

Stelara® 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 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: _____

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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South Dakota Department of Social Services

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

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
- ❑ Non-radiographic axial spondyloarthritis with objective of inflammation
- ❑ 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 or non-radiographic axial spondyloarthritis, 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?

_____

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Please note: This request may be denied unless all required information is received.
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This form may be used for non-urgent requests and faxed to 1-844-403-1029.

South Dakota Department of Social Services

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

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
❑ Moderate to severe psoriatic arthritis
❑ 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, calcipotriene, tazarotene, corticosteroid)? ❑ **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.
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South Dakota Department of Social Services

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

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
- ❑ Moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA)
- ❑ Active ankylosing spondylitis
- ❑ 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**

Has the patient had an inadequate response to, intolerance to, or contraindication to one or more TNF blockers (e.g., Cimzia, Enbrel, Humira, Simponi, Avsola, Inflectra, Renflexis, Remicade)? If so, which one(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.
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This form may be used for non-urgent requests and faxed to 1-844-403-1029.

South Dakota Department of Social Services

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

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)
- ❑ Nasal polyps with inadequate response to nasal steroid
- ❑ 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?

_____

_____

_____

Please note: This request may be denied unless all required information is received.
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South Dakota Department of Social Services

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

Juxtapid® 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)

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

Clinical information:

Is the patient's baseline LDL-C level greater than or equal to 190 mg/dL? ❑ **Yes** ❑ **No**

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

Has the patient had trial and failure of Praluent or Repatha? ❑ **Yes** ❑ **No**

If yes, what was the documented failure with Praluent or Repatha _____

_____

What is the medical rationale for use of Juxtapid over Praluent or Repatha? _____

_____

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.
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This form may be used for non-urgent requests and faxed to 1-844-403-1029.

South Dakota Department of Social Services

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

Extina, Xolgel™ & Xolegel™ Duo 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?

_____

_____

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_____

Please note: This request may be denied unless all required information is received.
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South Dakota Department of Social Services

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

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?

_____

_____

_____

_____

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South Dakota Department of Social Services

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

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?

_____

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_____

_____

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South Dakota Department of Social Services

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

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.
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This form may be used for non-urgent requests and faxed to 1-844-403-1029.

South Dakota Department of Social Services

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

Vusion® Prior Authorization Request Form

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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?

_____

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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.

South Dakota Department of Social Services

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

Makena® SubQ 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:

❑ Pregnancy indication, preterm birth

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

Clinical information:

1. Does the patient have a history of previous singleton (single offspring) spontaneous perterm birth(s)? ❑ **Yes** ❑ **No**
2. Is the patient having a singleton pregnancy? ❑ **Yes** ❑ **No**
3. Is the therapy starting between 16 weeks, 0 days and 20 weeks, 6 days of gestation? ❑ **Yes** ❑ **No**
4. Will therapy be continued until week 37 (through 36 weeks, 6 days) of gestation or delivery, which ever occurs first? ❑ **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.
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This form may be used for non-urgent requests and faxed to 1-844-403-1029.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

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	❑ Briumvi	❑ Gilenya	❑ Mavenclad	❑ Rebif
❑ Aubagio	❑ Copaxone	❑ Glatiramer	❑ Mayzent	❑ Tascenso ODT
❑ Avonex	❑ Dalfampridine ER	❑ Glatopa	❑ Plegridy	❑ Tecfidera
❑ Bafiertam	❑ Extavia	❑ Kesimpta	❑ Ponvory	❑ Vumerity
❑ Betaseron				❑ Zeposia

Select the diagnosis below:

❑ 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:

❑ 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, Bafiertam, Betaseron, Briumvi, Copaxone, Extavia, Gilenya, Glatiramer, Glatopa, Kesimpta, Lemtrada, Mayzent, Plegridy, Ponvory, Rebif, Tecfidera, or Vumerity, 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 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

South Dakota Department of Social Services

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

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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)
- ❑ Avonex (interferon beta-1a)
- ❑ Bafiertam (monomethyl fumarate)
- ❑ Betaseron (interferon beta-1b)
- ❑ Briumvi (ublituximab-xiiy)
- ❑ Copaxone/Glatopa (glatiramer acetate)
- ❑ Extavia (interferon beta-1b)
- ❑ Gilenya (fingolimod)
- ❑ Kesimpta (ofatumumab)
- ❑ Lemtrada (alemtuzumab)
- ❑ Mayzent (siponimod)
- ❑ Ocrevus (ocrelizumab)
- ❑ Plegridy (peginterferon beta-1a)
- ❑ Rebif (interferon beta-1a)
- ❑ Tecfidera (dimethyl fumarate)
- ❑ Tysabri (natalizumab)
- ❑ Vumerity (diroximel)
- ❑ Zeposia (ozanimod)

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.

South Dakota Department of Social Services

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

Tysabri® 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:

❑ Multiple Sclerosis (type) _____ ICD-10 Code(s): _____
❑ Crohn's Disease (severity level) _____ ICD-10 Code(s): _____
❑ Other _____ ICD-10 Code(s): _____

Prescriber's specialty:

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

❑ Neurologist
❑ Gastroenterologist
❑ Other _____

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.

South Dakota Department of Social Services

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

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.
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South Dakota Department of Social Services

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

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?

_____

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_____

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This form may be used for non-urgent requests and faxed to 1-844-403-1029.

South Dakota Department of Social Services

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

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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South Dakota Department of Social Services

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

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?

_____

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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.

South Dakota Department of Social Services

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

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
- ❑ Nighttime sleep disturbances in Smith-Magenis syndrome
- ❑ 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?

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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.

South Dakota Department of Social Services

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

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)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
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?

_____

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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.

South Dakota Department of Social Services

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

Sunosi™ & Wakix® 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 excessive daytime sleepiness
- ❑ Obstructive sleep apnea
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

For narcolepsy with excessive daytime sleepiness, answer the following:

Has the patient had a previous trial of at least one of the following standard stimulant agents: amphetamine/dextroamphetamine, armodafinil, modafinil, dextroamphetamine, methylphenidate? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

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

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

_____

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

Bepreve®, Lastacaft®, Pataday®, Patanol®, 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 5 day trial of azelastine, emedastine, epinastine, generic olopatadine, 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.

South Dakota Department of Social Services

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

Opzelura™ 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:

❑ Actopic dermatitis

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

Clinical information:

1. Does the patient have greater than or equal to 3% body surface area involvement? ❑ **Yes** ❑ **No**
2. Does it involve sensitive body areas (e.g., face, hands, feet, scalp, groin)? ❑ **Yes** ❑ **No**
3. Greater than or equal to 90 days of topical drug therapy with **one** of the following: corticosteroids, pimecrolimus and/or tacrolimus, crisaborole? ❑ **Yes** ❑ **No**
4. Is the patient using concurrently with therapeutic biologics, other Janus kinase inhibitors, or potent immunosuppressants such as azathioprine or cyclosporine? ❑ **Yes** ❑ **No**
5. What is the requested quantity? _____
6. How long will the patient be using Opzelura? _____

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.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

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: _____

South Dakota Department of Social Services

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

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.
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This form may be used for non-urgent requests and faxed to 1-844-403-1029.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

Tivorbex™ Prior Authorization Request Form

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

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

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

Clinical Information (required)

Has the patient had a trial and failure (a minimum of a combined 30 day trial) of two generic prescription strength nonsteroidal anti-inflammatory drugs (NSAIDs) in the past 180 days? ❑ **Yes** ❑ **No**

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

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.

South Dakota Department of Social Services

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

Conzip®, Synapryn®, Ultram® ER (tramadol ER biphasic capsule or tablet) Prior Authorization Request Form

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

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

Medication Information (required)

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

Clinical Information (required)

Clinical information:

Is the patient currently stable on tramadol ER tablet or Ultram ER? ❑ **Yes** ❑ **No**

Is the patient currently stable on Conzip, Synapryn (tramadol suspension), tramadol ER biphasic capsule or tablet? ❑ **Yes** ❑ **No**

Has the patient failed a 30 day trial of 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:_____

_____

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.

South Dakota Department of Social Services

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

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**

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.

South Dakota Department of Social Services

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

Onzetra® Xsail® Prior Authorization Request Form

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

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

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

Clinical Information (required)

Has the patient had a trial and failure to at least six other triptans in the past 36 months? ❑ **Yes** ❑ **No**

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

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.

South Dakota Department of Social Services

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

Nurtec ODT™, Qulipta™, Reyvow®, Ubrelvy™ 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 treatment of migraine with or without aura
- ❑ Preventive treatment of episodic migraine in adults
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Has the patient had a trial and failure of a triptan in the last 120 days? ❑ **Yes** ❑ **No**

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

Does the patient have cardiovascular disease? ❑ **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.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

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.

South Dakota Department of Social Services

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

Xifaxan® Prior Authorization Request Form

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

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

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

Clinical Information (required)

Select the diagnosis below:

- ❑ Hepatic encephalopathy (HE)
- ❑ Irritable bowel syndrome with diarrhea (IBS-D)
- ❑ Travelers' diarrhea
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

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

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.

South Dakota Department of Social Services

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

Ambien CR®, 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?

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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.

South Dakota Department of Social Services

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

Belsomra®, Dayvigo®, Quviviq™ 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 180 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?

_____

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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.

INTRODUCTION

- Attention-deficit/hyperactivity disorder (ADHD) is the most common neurodevelopmental disorder among children, with an estimated prevalence of up to 10% in school-age children in the United States (US). It is more common in boys than girls and frequently persists into adulthood (*Centers for Disease Control and Prevention [CDC] 2021, Feldman et al 2014*). Epidemiologic studies of adult ADHD have estimated the current prevalence to be 4.4% in the US. (*Bukstein 2022*).
  - In children, this chronic disorder is characterized by symptoms of hyperactivity, impulsivity, and/or inattention. These symptoms affect cognitive, academic, behavioral, emotional, and social functioning (*Krull 2022a*). Common comorbid psychiatric disorders include oppositional defiant disorder, conduct disorder, depression, anxiety disorder, and learning disabilities (*Krull 2022b*). Approximately 20% of children with ADHD develop chronic tic disorders and approximately 50% of children with chronic tics or Tourette syndrome have comorbid ADHD (*Krull 2022c*).
  - ADHD in adults is characterized by symptoms of inattention, impulsivity, and restlessness. Impairment in executive function and emotional dysregulation frequently occur. Common comorbid psychiatric disorders include mood and anxiety disorders, substance use disorder, and intermittent explosive disorder (*Bukstein 2022*).
- For children < 17 years of age, the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) diagnosis of ADHD requires ≥ 6 symptoms of hyperactivity and impulsivity or ≥ 6 symptoms of inattention. For adolescents ≥ 17 years of age and adults, ≥ 5 symptoms of hyperactivity and impulsivity or ≥ 5 symptoms of inattention are required.
  - The symptoms of hyperactivity/impulsivity or inattention must occur often; be present in more than 1 setting; persist for at least 6 months; be present before the age of 12 years; impair function in academic, social, or occupational activities; and be excessive for the developmental level of the child.
  - Other physical, situational, or mental health conditions that could account for the symptoms must be excluded.
- Treatment of ADHD may involve behavioral/psychologic interventions, medication, and/or educational interventions, alone or in combination (*Krull 2022d*).
  - For preschool children (age 4 through 5 years), behavioral therapy is considered the first-line treatment; when medication is necessary, methylphenidate is generally recommended.
  - For children and adolescents with moderate to severe ADHD, medication and behavioral therapy are recommended. In general, stimulants are the first-line agents; however, nonstimulant medications may be more appropriate for certain children.
    - Some patients do not respond to or may not tolerate the initial stimulant treatment. At least one-half of children who do not respond to one type of stimulant will respond to the other. If there is still no improvement, consideration should be given to switching to or adding a nonstimulant ADHD medication (*Krull 2022e*).
- Multiple agents are currently approved by the Food and Drug Administration (FDA) for the treatment of ADHD. They include central nervous system (CNS) stimulants (amphetamine- and methylphenidate-based formulations), as well as nonstimulants: 2 selective norepinephrine reuptake inhibitors (SNRIs), atomoxetine and viloxazine extended-release (ER); and 2 alpha$_2$-adrenergic agonists, clonidine ER and guanfacine ER.
  - Due to the potential for abuse, the stimulant agents are classified as Schedule II controlled substances.
  - Several stimulants are also approved for the treatment of narcolepsy and exogenous obesity; the use of stimulants for the treatment of obesity will not be covered in this review. Lisdexamfetamine dimesylate is the only FDA-approved drug for the treatment of binge eating disorder (BED).
- Medispan Classes: ADHD Agents – Amphetamines, Dexmethylphenidate, Methylphenidate, Selective Alpha-Adrenergic Agonists, Selective Norepinephrine Reuptake Inhibitor

Table 1. Medications Included Within Class Review

Drug	Generic Availability
Stimulants	
Evekeo (amphetamine sulfate)	✔
Evekeo ODT (amphetamine sulfate)	-
Azstarys (serdexmethylphenidate/dexmethylphenidate)	-
Adderall (mixed amphetamine salts)	✔
Focalin (dexmethylphenidate hydrochloride [HCl])	✔
ProCentra (dextroamphetamine sulfate)	✔
Zenzedi (dextroamphetamine sulfate)	✔
Xelstrym (dextroamphetamine transdermal system)	-
Desoxyn (methamphetamine HCl)	✔
methylphenidate HCl chewable tablets	✔
Methylin Oral Solution (methylphenidate HCl)	✔
Ritalin (methylphenidate HCl)	✔
Dexedrine Spansule (dextroamphetamine sulfate sustained-release)	✔
Adzenys XR-ODT (amphetamine ER)	-
Dyanavel XR (amphetamine ER)	-
Adderall XR (mixed amphetamine salts ER)	✔
Mydayis (mixed amphetamine salts ER)	-
Focalin XR (dexmethylphenidate HCl ER)	✔
Vyvanse (lisdexamfetamine dimesylate)	-
Adhansia XR (methylphenidate HCl ER)*	-
Aptensio XR (methylphenidate HCl ER)	✔
Concerta (methylphenidate HCl ER)	✔
Cotempla XR-ODT (methylphenidate ER)	-
Jornay PM (methylphenidate HCl ER)	-
methylphenidate HCl ER (CD)	✔
methylphenidate HCl ER	✔
QuilliChew ER (methylphenidate HCl ER)	-
Quillivant XR (methylphenidate HCl ER)	-
Relexxii (methylphenidate HCl ER) (72 mg)	✔
Ritalin LA (methylphenidate HCl ER)	✔
Daytrana (methylphenidate transdermal system)	✔
Nonstimulants	
Strattera (atomoxetine HCl)	✔
Kapvay (clonidine HCl ER)	✔
Intuniv (guanfacine HCl ER)	✔
Qelbree (viloxazine ER)	-

*Adhansia XR was discontinued by the manufacturer in July 2022.

(*Drugs@FDA 2022, Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations 2022, Clinical Pharmacology 2022*)

INDICATIONS

Table 2. Food and Drug Administration Approved Indications

Indication	ADHD*	ADHD, as an integral part of a total treatment program which typically includes other remedial measures (psychological, educational, and social) for a stabilizing effect in pediatric patients with a behavioral syndrome characterized by the following group of developmentally inappropriate symptoms: moderate to severe distractibility, short attention span, hyperactivity, emotional lability, and impulsivity. The diagnosis of this syndrome should not be made with finality when these symptoms are only of comparatively recent origin. Nonlocalizing (soft) neurological signs, learning disability, and abnormal electroencephalogram (EEG) may or may not be present, and a diagnosis of CNS dysfunction may or may not be warranted.*	Treatment of ADHD as monotherapy and as adjunctive therapy to stimulant medications	Narcolepsy**	Exogenous obesity, as a short term (a few weeks) adjunct in a regimen of weight reduction based on caloric restriction for patients refractory to alternative therapy (eg, repeated diets, group programs, and other drugs).†	Moderate to severe BED in adults
Evekeo (amphetamine sulfate)		✓		✓	✓	
Evekeo ODT (amphetamine sulfate)	✓					
Adzenys XR-ODT, Dyanavel XR (amphetamine)	✓					
Adderall (mixed amphetamine salts)	✓			✓		
Adderall XR, Mydayis (mixed amphetamine salts ER)	✓					
Strattera (atomoxetine HCl)	✓					
Kapvay (clonidine HCl ER)			✓			
Focalin (dexmethylphenidate IR); Focalin XR (dexmethylphenidate ER)	✓					
ProCentra, Zenzedi (dextroamphetamine sulfate IR); Dexedrine Spansule (dextroamphetamine sulfate SR)		✓		✓		
Intuniv (guanfacine HCl ER)			✓			
Vyvanse (lisdexamfetamine dimesylate)	✓					✓

Desoxyn (methamphetamine HCl)		✓				
Ritalin (methylphenidate HCl IR); methylphenidate HCl chewable tablets		✓		✓		
Methylin Oral Solution; methylphenidate ER tablets	✓			✓		
Adhansia XR, Aptensio XR, Concerta, Cotempla XR-ODT, Daytrana, Jornay PM, QuilliChew ER, Quillivant XR, Relexxii, Ritalin LA (methylphenidate ER)	✓					
Azstarys (serdexmethylphenidate/dexmethylphenidate)	✓					
Qelbree (viloxazine ER)	✓					
Xelstrym (dextroamphetamine transdermal)	✓					

(*Prescribing Information*: *Adderall 2022*, *Adderall XR 2022*, *Adhansia XR 2021*, *Adzenys XR-ODT 2022*, *Aptensio XR 2021*, *Azstarys 2021, Concerta 2022*, *Cotempla XR-ODT 2021*, *Daytrana 2021, Desoxyn 2019, Dexedrine Spansule 2022*, *Dyanavel XR 2022*, *Evekeo 2022*, *Evekeo ODT 2021*, *Focalin 2021*, *Focalin XR 2021, Intuniv 2020, Jornay PM 2021, Kapvay 2020, Mydayis 2022, Methylin Oral Solution 2021, methylphenidate chewable tablets 2021, methylphenidate ER 2021, methylphenidate ER (CD) 2021, ProCentra 2021*, *Qelbree 2022, QuilliChew ER 2021*, *Quillivant XR 2021*, *Relexxii 2019, Ritalin 2021*, *Ritalin LA 2021*, *Strattera 2022*, *Vyvanse 2022, Xelstrym 2022, Zenzedi 2022*)

*Adderall, Evekeo, ProCentra, and Zenzedi are approved for use in children 3 years of age and older. Evekeo ODT is approved for use in patients 3 to 17 years of age. Daytrana, Desoxyn, Dexedrine Spansule, Intuniv, and Kapvay are approved for use in children 6 years of age and older. Adderall XR, Adhansia XR, Adzenys XR-ODT, Aptensio XR, Azstarys, Dyanavel XR, Focalin, Focalin XR, Jornay PM, methylphenidate ER (CD), methylphenidate ER, Methylin Oral Solution, methylphenidate chewable tablets, Qelbree, QuilliChew ER, Quillivant XR, Ritalin, Strattera, Vyvanse, and Xelstrym are approved for use in patients 6 years of age and older. Cotempla XR-ODT is approved for use in pediatric patients 6 to 17 years of age. Ritalin LA is approved for use in pediatric patients 6 to 12 years of age. Concerta and Relexxii are approved for use in children 6 years of age and older, adolescents, and adults up to 65 years of age. Mydayis is approved for use in patients 13 years of age and older.
**These drugs are approved for use in patients 6 years of age and older.
†These drugs are not recommended for use in children under 12 years of age for treatment of exogenous obesity. The limited usefulness of these products should be weighed against possible risks inherent in use of the drugs.

- Limitation of use:
  - Aptensio XR: Pediatric patients younger than 6 years of age experienced higher plasma exposure than patients 6 years and older at the same dose and high rates of adverse events (AEs), most notably weight loss.
  - Lisdexamfetamine: Pediatric patients younger than 6 years of age experienced more long-term weight loss than patients 6 years and older. Lisdexamfetamine is not indicated or recommended for weight loss. Use of other sympathomimetic drugs for weight loss has been associated with serious cardiovascular (CV) AEs. The safety and effectiveness of this drug for the treatment of obesity have not been established.
  - Mydayis: Pediatric patients 12 years and younger experienced higher plasma exposure than patients 13 years and older at the same dose and experienced higher rates of AEs, mainly insomnia and decreased appetite.
  - Xelstrym: Pediatric patients younger than 6 years of age experienced more long-term weight loss than patients 6 years and older.

- 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

- Randomized trials, systematic reviews, and meta-analyses have found stimulants, SNRIs (atomoxetine, viloxazine ER), and alpha$_2$-adrenergic agonists (clonidine ER, guanfacine ER) to be more efficacious than placebo in reducing the core symptoms of ADHD in children and adolescents.

- Evekeo (amphetamine sulfate) was approved based on a randomized, double-blind (DB), multicenter (MC), placebo-controlled (PC) laboratory classroom study that was conducted in 107 children between the ages of 6 and 12 years (*Childress et al 2015*). The study found Evekeo to be associated with significant improvements in the average Swanson, Kotkin, Agler, M-Flynn, and Pelham (SKAMP) combined score compared to placebo (least squares [LS] mean difference -7.9; 95% confidence interval [CI], -10.1 to -5.6; $p < 0.0001$).
  - Evekeo ODT, an orally disintegrating amphetamine tablet, was approved under the 505(b)(2) regulatory pathway. The safety and effectiveness of Evekeo ODT for the treatment of ADHD was established based on an adequate and well-controlled study of Evekeo (*Childress et al 2015*).
- Cotempla XR-ODT, a new methylphenidate ER orally disintegrating tablet formulation, was approved based on a randomized, DB, MC, PC laboratory classroom study (*Childress et al 2017*) (N = 87) which found that the average SKAMP-combined score was significantly better for Cotempla XR-ODT than for placebo (LS mean 14.3 [95% CI, 12.2 to 16.4] vs 25.3 [9% CI, 23.0 to 27.6], respectively; $p < 0.0001$).
- Adhansia XR (methylphenidate ER capsule) was approved via the 505(b)(2) regulatory pathway, and its efficacy was supported by 4 clinical studies in patients with ADHD including 2 studies conducted in adults, 1 study in adolescents 12 to 17 years of age, and 1 study in pediatric patients 6 to 12 years of age (*Adhansia XR FDA Clinical Review 2019):*
  - One randomized, DB, MC, PC 4-week study conducted in 368 adult patients with ADHD evaluated the safety and efficacy of 4 doses of Adhansia XR (25, 45, 70, and 100 mg) compared to placebo. The primary endpoint, change in the ADHD-Rating Scale (ADHD-RS)-5 total score from baseline to Week 5, was significantly improved compared to placebo in the Adhansia XR 45 mg group (LS mean difference, -6.9; 95% CI, -11.5 to -2.2; $p = 0.0013$), 100 mg group (LS mean difference, -8.1; 95% CI, -12.9 to -3.2; $p = 0.0002$), and when combining all dosage groups compared to placebo (LS mean difference, -4.7; 95% CI, -7.7 to -1.6; $p = 0.0026$). No significant difference was seen in the 25 mg or 70 mg groups compared to placebo.
- A second randomized, DB, crossover, PC study was conducted in 45 adults in an adult workplace environment (*Adhansia XR FDA Clinical Review 2019, Wigal et al 2020*). The study aimed to assess efficacy parameters for Adhansia XR vs placebo over 16 hours post-dose. Patients were titrated to an optimal dose of Adhansia XR (either 25, 35, 45, 55, 70, 85, or 100 mg) during an open-label (OL) treatment period between 2 and 7 weeks, then entered into a 1-week PC, DB treatment phase prior to the adult workplace environment session, followed by a 7-day washout period between crossover periods, then another 1-week treatment phase followed by another adult workplace environment session. The primary endpoint was the average Permanent Product Measure of Performance (PERMP) score for various time points up to 16 hours post-dose. When combining data from all time points, patients treated with Adhansia XR had significant improvements in the PERMP score compared to placebo (LS mean difference, 13.05; 95% CI, 3.88 to 22.23; $p = 0.0064$).
- A 4-week randomized, DB, PC trial assessed efficacy of Adhansia XR in 354 adolescent patients 12 to 17 years of age (*Adhansia XR FDA Clinical Review 2019)*. The study compared Adhansia XR 25, 45, 70, and 85 mg to placebo and found significant improvements in the ADHD-5-RS score from baseline to Week 5 in adolescents treated with Adhansia XR 45 mg (LS mean difference, -5.4; 95% CI, -9.2 to -1.6; $p = 0.0052$), 70 mg (LS mean difference, -5.2; 95% CI, -9.0 to -1.4; $p = 0.0069$), and when combining all dosage groups compared to placebo (LS mean difference, -4.3; 95% CI, -7.3 to -1.3; $p = 0.0049$). Adolescents treated with Adhansia XR 25 or 85 mg did not achieve significant improvements in the ADHD-5-RS score compared to placebo.
  - A fourth study, which included a 6-week OL dose optimization period (majority of patients received between 45 and 55 mg of Adhansia XR) followed by a 1- week DB, PC study, was conducted to assess the efficacy of Adhansia XR in 147 children 6 to 12 years of age in an analog classroom setting. The primary endpoint, average SKAMP-C score (taken at various time points up to 13 hours post-dose), was significantly improved in children treated with Adhansia XR compared to placebo (LS mean difference, -8.6; 95% CI, -10.6 to -6.6).
- Jornay PM, an ER methylphenidate capsule formulation, was approved based on the results of 2 clinical studies conducted in patients 6 to 12 years of age with ADHD:
  - The first study was a 6-week OL dose-optimization study, followed by a 1-week DB, PC withdrawal phase where patients were randomized to continue treatment with Jornay PM or switch to placebo (*Childress et al 2020, Jornay PM Prescribing Information 2021*). The study, which was conducted in an analog classroom setting and included 117 children aged 6 to 12 years, found that Jornay PM was associated with a significant reduction in the SKAMP symptom score over a 12-hour period (LS mean difference, -5.9; 95% CI, -9.1 to -2.7).
  - A randomized, DB, MC, PC, parallel group, forced-dose titration trial was conducted over 3 weeks in 161 children 6 to 12 years of age with ADHD (*Pliszka et al 2017*). The study found that 40 to 80 mg/day of Jornay PM achieved significant improvements vs placebo in ADHD symptoms (LS mean ADHD rating scale-IV, 24.1 vs 31.2; $p = 0.002$)

at 3 weeks. Significant improvements were also seen vs placebo in key secondary outcomes including at-home early morning and late afternoon/evening functional impairment at 3 weeks. The most commonly reported treatment-emergent AEs were insomnia and decreased appetite.

- Mydayis, a mixed amphetamine salts product, was approved for the treatment of ADHD based on the results of 5 MC, DB, PC, randomized controlled trials (RCTs): 3 in adults and 2 in pediatric patients 13 to 17 years of age. The studies found that Mydayis demonstrated a statistically significant treatment effect compared with placebo on various ADHD outcomes measures (eg, ADHD-RS score, PERMP score) (*Mydayis Prescribing Information 2022, Weisler et al 2017, Wigal et al 2018a, Wigal et al 2018b, Wigal et al 2019*) (see results below in Table 3 below). An additional 6-week, randomized, PC, DB, forced dose titration trial in 411 adults with ADHD similarly found that Mydayis significantly improved ADHD-RS-IV scores compared to placebo (LS mean treatment difference for all Mydayis doses combined vs placebo, -10.6; 95% CI, -13.2 to -8.0; p < 0.0001) (*Frick et al 2020*).

Table 3. Summary of Primary Efficacy Results for Mydayis

Study Number (Age range)	Primary Endpoint	Treatment Group	Mean Baseline Score (SD)	LS Mean Change from Baseline	Placebo-subtracted Difference (95% CI)
Adult Studies					
Study 1 (18 to 55 years)	ADHD-RS	Mydayis 12.5 mg/day§ Mydayis 37.5 mg/day§ Placebo	39.8 (6.38) 39.9 (7.07) 40.5 (6.52)	-18.5 -23.8 -10.4	-8.1 (-11.7 to -4.4) -13.4 (-17.1 to -9.7)
Study 2 (18 to 55 years)	Average PERMP	Mydayis 50 mg/day§ Placebo	239.2 (75.6)† 249.6 (76.7)†	293.23* 274.85*	18.38 (11.28 to 25.47)
Study 3 (18 to 55 years)	Average PERMP	Mydayis 25 mg/day§ Placebo	217.5 (59.6)† 226.9 (61.7)†	267.96* 248.67*	19.29 (10.95 to 27.63)
Pediatric Studies					
Study 4 (13 to 17 years)‡	ADHD-RS-IV	Mydayis 12.5 to 25 mg/day§ Placebo	36.7 (6.15) 38.3 (6.67)	-20.3 -11.6	-8.7 (-12.6 to -4.8)
Study 5 (13 to 17 years)	Average PERMP	Mydayis 25 mg/day§ Placebo	214.5 (87.8)† 228.7 (101)†	272.67* 231.41*	41.26 (32.24 to 50.29)

SD = standard deviation; LS = least squares; CI = confidence interval
†Pre-dose PERMP total score
*LS mean for PERMP is post-dose average score over all sessions of the treatment day, rather than change from baseline
‡Results are for a subgroup of study 4 and not the total population
§Doses statistically significant for placebo

- Azstarys, a combination of serdexmethylphenidate and dexmethylphenidate, was approved based on results from a randomized, DB, PC analog classroom study *(Kollins et al 2021)*. A total of 150 patients aged 6 to 12 years were enrolled. Following an OL, 3-week dose titration phase, patients were randomly assigned during a 1-week parallel treatment period to either the optimized dose Azstarys or placebo. After 1 week, evaluations were done using the SKAMP rating scale over 13 hours in a classroom setting. Mean change in SKAMP from baseline (primary outcome) was significantly greater with Azstarys compared with placebo (placebo-subtracted difference -5.41; 95% CI, -7.10 to -3.71; p < 0.001). The efficacy of Azstarys in adults and pediatric patients 13 to 17 years of age was established by pharmacokinetic bridging between Azstarys and Focalin XR (dexmethylphenidate ER) capsules.
- Qelbree (viloxazine ER), an SNRI, was shown to be superior to placebo in 3 DB, MC, randomized, PC trials in pediatric patients with ADHD.
  - Trial 1 enrolled 313 patients aged 6 to 11 years who were randomized to treatment with viloxazine ER 200 or 400 mg or placebo once daily for 8 weeks (*Nasser 2021b*). Improvements in ADHD-RS-5 total scores were reported, with LS mean changes from baseline of -17.6, -17.5 and -11.7 for viloxazine ER 200 mg, 400 mg, and placebo, respectively (p < 0.05 for both comparisons to placebo).

- Trial 2 enrolled 477 patients aged 6 to 11 years who were randomized to either viloxazine ER 100 mg or 200 mg or placebo once daily for 6 weeks (*Nasser 2020*). LS mean changes from baseline in ADHD-RS-5 total scores were -16.6, -17.7, and -10.9 for viloxazine ER 100 mg, 200 mg, and placebo, respectively ($p < 0.05$ and $p < 0.0001$ for viloxazine ER 100 mg and 200 mg vs placebo, respectively).
- A third trial evaluated viloxazine ER in 310 patients aged 12 to 17 years of age who were randomized to viloxazine ER 200 mg, 400 mg, or placebo (*Nasser 2021a*). After 6 weeks of treatment, viloxazine ER 200 mg and 400 mg resulted in LS mean changes from baseline in ADHD-RS-5 total scores of -16.0, -16.5, and -11.4 for viloxazine ER 200 mg, 400 mg, and placebo, respectively ($p < 0.05$ vs placebo for both comparisons).

- The Dyanavel XR (amphetamine ER) tablet was approved in November 2021 for the treatment of patients 6 years and older. The pharmacokinetic profile of the Dyanavel XR tablet was established to be bioequivalent to that of the Dyanavel XR oral suspension (*Dyanavel XR Prescribing Information 2022*). The safety and efficacy of the ER tablet were evaluated in a randomized, DB, PC, fixed-dose study in 130 adult patients with ADHD (*Cutler et al 2022a*). Patients entered a 5-week, DB, dose-titration phase in which they were randomized to receive Dyanavel XR tablet or matching placebo once daily in the morning. The starting dose of 5 mg was titrated in 5-mg increments per week, and patients received a final dose of 20 mg for 14 ± 3 days before visit 5. The primary endpoint of mean PERMP-Total score (PERMP-T) across all postdose time points at visit 5 was significantly higher (improved) in the Dyanavel XR tablet group compared to the placebo group (302.8 vs 279.6; $p = 0.0043$).
- Xelstrym (dextroamphetamine transdermal system) was approved by the FDA in 2022 for the treatment of ADHD in adults and pediatric patients aged 6 to 17 years. Its efficacy was supported by previous, well-controlled studies of lisdexamfetamine in pediatric and adult patients, in addition to a MC, DB, randomized, PC, modified analog classroom study in pediatric patients aged 6 to 17 years *(Cutler et al 2022b)*. The study was conducted in 2 periods, and Xelstrym patches delivering different doses (5, 10, 15, and 20 mg) were evaluated. Patients were enrolled in a 5-week, OL, stepwise dose-optimization period in which they were started on a 5-mg patch and evaluated weekly for possible adjustments to the next dose level. Once the optimal dose was reached, it was maintained during a 2-week, crossover, DB treatment period. A total of 106 patients entered the DB treatment period. The study found Xelstrym to be associated with significant improvement in the SKAMP total score compared to placebo (LS mean difference -5.87; 95% CI, 6.76 to -4.97; $p < 0.001$).
- A systematic (Cochrane) review of 185 RCTs (*Storebø et al 2015*) (N = 12,245) in children and adolescents with ADHD found that methylphenidate may improve teacher-rated ADHD symptoms, teacher-reported general behavior, and parent-reported quality of life (QOL) vs placebo. However, the evidence was of low quality.
- An RCT called the Preschool ADHD Treatment Study (PATS) (*Greenhill et al 2006*) evaluated the efficacy of methylphenidate immediate-release (IR) in 303 preschool children with ADHD and found that it demonstrated significant reductions on ADHD symptom scales; however, the effect sizes (0.4 to 0.8) were smaller than those generally reported for school-age children.
- A systematic (Cochrane) review of 23 PC, RCTs (*Punja et al 2016*) (N = 2675) found that amphetamines were effective at improving the core symptoms of ADHD, but they were also associated with a higher risk of AEs compared to placebo. There was no evidence that one kind of amphetamine was better than another and there was no difference between short-acting and long-acting formulations.
- A meta-analysis of 25 DB, PC, RCTs (*Schwartz et al 2014*) (N = 3928) in children and adolescents with ADHD found atomoxetine to be superior to placebo for overall ADHD symptoms, with a medium effect size (-0.64).
- A meta-analysis of 25 RCTs (all rated as low or very low quality evidence) in children with autism and concurrent ADHD symptoms concluded that methylphenidate and atomoxetine both reduced parent-rated hyperactivity and inattention (*Rodrigues et al 2021*). Methylphenidate also reduced teacher-rated hyperactivity and inattention, but atomoxetine only reduced teacher-rated inattention.
- A meta-analysis of 12 RCTs (*Hirota et al 2014*) (N = 2276) in pediatric patients with ADHD found that alpha$_2$-adrenergic agonists were significantly superior to placebo for overall ADHD symptoms both as monotherapy and, to a lesser extent, as augmentation therapy to stimulants.
  - Meta-analytic results failed to demonstrate a significant difference in efficacy between alpha$_2$-adrenergic agonists. In sub-analyses of individual formulations, the ER formulations separated robustly from placebo whereas the IR formulations did not separate from placebo.
- A systematic review of 16 RCTs and 1 meta-analysis (*Chan et al 2016*) (N = 2668) found evidence supporting the use of methylphenidate ER and amphetamine ER formulations, atomoxetine, and guanfacine ER for the treatment of ADHD in adolescents. For the primary outcome measure of mean change in ADHD-RS total symptom score, both stimulant and nonstimulant medications led to clinically significant reductions of 14.93 to 24.60 points.

- For the treatment of ADHD in children and adolescents, stimulants typically have a slightly larger treatment effect size (standardized mean difference [SMD]) than nonstimulants (approximately 1.0 vs approximately 0.7 for both atomoxetine and alpha$_2$-adrenergic agonists). However, there is insufficient evidence to definitively conclude that one stimulant is more efficacious than another (*Krull 2022e*, *Wolraich et al 2019).*
  - An Agency for Healthcare Research and Quality (AHRQ) review of 78 studies (*Jadad et al 1999*) evaluating the efficacy of various interventions for the treatment of ADHD in children and adults found few, if any, differences between methylphenidate and dextroamphetamine.
  - A meta-analysis of 23 DB, PC trials (*Faraone 2010a*) comparing the efficacy of methylphenidate and amphetamine formulations found that amphetamine products may be moderately more efficacious than methylphenidate products.
  - A DB, PC, RCT (*Newcorn et al 2008*) (N = 516) comparing the efficacy of atomoxetine vs methylphenidate ER (osmotic-release formulation) in patients 6 to 16 years of age with ADHD found that both drugs were superior to placebo in terms of response rate, and that methylphenidate ER was superior to atomoxetine.
  - A meta-analysis of 29 DB, PC trials (*Faraone et al 2006*) evaluated the efficacy of various medications (methylphenidate and amphetamine compounds, atomoxetine, pemoline [no longer available in the US], bupropion, and modafinil) for the treatment of ADHD. The effect sizes for nonstimulant medications were significantly less than those for IR stimulants or long-acting stimulants. The 2 classes of stimulant medications did not differ significantly from one another.
  - A meta-analysis of 28 DB, PC, RCTs (*Stuhec et al 2015*) (N = 4699) compared the efficacy of various medications for the treatment of ADHD in children and adolescents. Efficacy in reducing ADHD symptoms compared to placebo was small for bupropion (SMD, -0.32; 95% CI, -0.69 to 0.05), modest for atomoxetine (SMD, -0.68; 95% CI, -0.76 to -0.59) and methylphenidate (SMD, -0.75; 95% CI, -0.98 to -0.52), and highest for lisdexamfetamine (SMD, -1.28; 95% CI, -1.84 to -0.71).
  - A network meta-analysis and mixed treatment comparison of 36 RCTs (*Joseph et al 2017*) evaluating the comparative efficacy and safety of ADHD pharmacotherapies in children and adolescents found that lisdexamfetamine had greater efficacy than guanfacine ER, atomoxetine, and methylphenidate ER. Guanfacine ER had a high posterior probability of being more efficacious than atomoxetine, but their credible intervals overlapped.
  - A network meta-analysis of 48 DB, RCTs (*Padilha et al 2018*) compared the safety and efficacy of various ADHD medications in children and adolescents. Of the 12 trials that were evaluated for efficacy, analysis was performed using the Clinical Global Impression Improvement (CGI-I) scale for 3 drugs, which showed that methylphenidate was more effective than atomoxetine (MD, 3.15; 95% CI, 0.75 to 13.71) and guanfacine (MD, 1.92; 95% CI, 0.64 to 5.94). Thirty-three trials were evaluated for safety. Ranking of AEs showed that lisdexamfetamine was more likely to cause sleep disorders, loss of appetite, and behavior problems compared to other treatments.
- Alpha$_2$-adrenergic agonists have been associated with improvements in ADHD symptoms and comorbid tics.
  - A meta-analysis of 9 DB, PC, RCTs (*Bloch et al 2009*) (N = 477) was conducted to determine the relative efficacy of different medications in treating ADHD and tic symptoms in children with both Tourette syndrome and ADHD.
  - Methylphenidate seemed to offer the greatest improvement of ADHD symptoms and did not seem to worsen tic symptoms.
  - Alpha$_2$-adrenergic agonists offered the best combined improvement in both tic and ADHD symptoms.
  - Atomoxetine significantly improved both tic and ADHD severity compared to placebo.
  - One small study found that tic severity was significantly increased with higher doses of dextroamphetamine treatment.
  - A Cochrane review of 8 RCTs (*Osland et al 2018*) including 510 children with both ADHD and a chronic tic disorder found low-quality evidence for improvement of ADHD symptoms with methylphenidate, atomoxetine, and clonidine, and very low-quality evidence for desipramine, dextroamphetamine, guanfacine, and deprenyl. Tic symptoms improved with guanfacine, desipramine, methylphenidate, clonidine, and a combination of methylphenidate and clonidine. The authors noted that in 1 study with a short duration (3 weeks), high doses of dextroamphetamine worsened tics.
- There are limited efficacy data regarding the treatment of ADHD in the adult population. Comparison of effect sizes in clinical trials suggests that stimulant medications are more efficacious in adult ADHD than nonstimulants.
  - In April 2022, the FDA approved an expanded indication for Qelbree for the treatment of ADHD in adults based on the results of a DB, MC, randomized, PC, flexible-dose, parallel-group monotherapy trial (*Qelbree Prescribing Information 2022, Nasser 2022)*. A total of 374 patients with ADHD aged 18 to 65 years were randomized to receive viloxazine ER (flexible dose of 200 to 600 mg/day) or matching placebo for 6 weeks. The primary and secondary endpoints were the change in the Adult ADHD Investigator Symptom Rating Scale (AISRS) total score and the Clinical Global Impressions-Severity of Illness (CGI-S) score, respectively, from baseline at end of study. Patients in the viloxazine

ER group had a greater reduction in the AISRS total score than the placebo group (LS mean change, -15.5 vs -11.7; p = 0.0040). A significantly greater reduction in the CGI-S score was also seen in patients treated with viloxazine ER compared to placebo (LS mean change, -1.4 vs -1.0; p = 0.0023).

- In a meta-analysis of 12 clinical trials (*Cunill et al 2013*) (N = 3375) comparing atomoxetine with placebo in adult ADHD, atomoxetine led to a modestly greater reduction in ADHD symptom severity but was associated with higher all-cause discontinuation.
- A meta-analysis (*Faraone 2010b*) of 19 randomized trials of 13 medications for adult ADHD found a greater average effect size for reduction in ADHD symptoms in patients receiving short- and long-acting stimulant medications (vs placebo; 0.86 and 0.73, respectively) compared with patients receiving nonstimulant medication (vs placebo; 0.39). No difference in effect size was found between short- and long-acting stimulants.
- A meta-analysis of 20 randomized trials (*Stuhec et al 2019*) compared the efficacy, acceptability, and tolerability of lisdexamfetamine, mixed amphetamine salts, methylphenidate, and modafinil in the treatment of ADHD in adults. The highest effect size in reducing ADHD symptoms was found with lisdexamfetamine (SMD -0.89; 95% CI, -1.09 to -0.70), while moderate reductions in symptoms were seen with mixed amphetamine salts (SMD -0.64; 95% CI, -0.83 to -0.45) and methylphenidate (SMD -0.50; 95% CI, -0.58 to -0.41). No efficacy was reported with modafinil.
- A Cochrane review of 19 studies (*Castells et al 2018*, N = 2521) comparing dextroamphetamine, lisdexamfetamine, and mixed amphetamine salts for the treatment of ADHD in adults found that overall, amphetamines reduced the patient- and clinician-rated severity of ADHD symptoms compared to placebo; however, they did not improve retention in treatment. Amphetamines were associated with an increased proportion of patients who withdrew because of AEs. When comparing different types of amphetamines, lisdexamfetamine and mixed amphetamine salts reduced the severity of ADHD symptoms as rated by clinicians, but dextroamphetamine did not. No differences in any outcome were found when comparing immediate- and sustained-release formulations.
- A systematic review and network meta-analysis (*Elliot et al 2020*) of 81 RCTs compared methylphenidate, atomoxetine, dexamfetamine, lisdexamfetamine, guanfacine, mixed amphetamine salts, modafinil, and bupropion for the treatment of ADHD in adults. Treatment with any ADHD pharmacotherapy was associated with statistically significant improvement in patient-reported clinical response vs placebo. When drugs were analyzed individually, only atomoxetine was found to significantly improve patient-reported clinical response compared to placebo (mean difference [MD], -5.9; 95% CI, -12.6 to -0.4). Atomoxetine (MD, -3.7; 95% CI, -6.7 to -0.9), sustained-release methylphenidate (MD, -5.7; 95% CI, -11.2 to -0.3), and low-dose methylphenidate (MD, -10.4; 95% CI, -19.0 to -2.1) were found to improve clinician-assessed clinical response compared to placebo. No significant differences were observed between individual medications when response was considered as a continuous outcome.
- Another meta-analysis (*Cortese et al 2018*) of 133 RCTs comparing the use of amphetamines, atomoxetine, bupropion, clonidine, guanfacine, methylphenidate, and modafinil for the treatment of ADHD found that all drugs were superior to placebo for ADHD core symptoms as rated by clinicians in children and adolescents, and all drugs except for modafinil were more efficacious than placebo in adults.
  - When comparing the various drugs based on teachers' ratings in children and adolescents, only methylphenidate and modafinil were found to be more efficacious than placebo.
  - In head-to-head comparisons, differences in efficacy based on clinicians' ratings were found, favoring amphetamines over modafinil (SMD, -0.39; 95% CI -0.67 to -0.12), atomoxetine (SMD, -0.46; 95% CI, -0.65 to -0.27), and methylphenidate (SMD, -0.24; 95% CI, -0.44 to -0.05) in children and adolescents. Efficacy results based on clinicians' ratings were similar for adults, and favored amphetamines over modafinil (SMD, -0.94; 95% CI -1.43 to -0.46), atomoxetine (SMD, -0.34; 95% CI, -0.58 to -0.10), and methylphenidate (SMD, -0.29; 95% CI, -0.54 to -0.05).

- Lisdexamfetamine dimesylate has demonstrated efficacy in the treatment of BED. Direct comparison trials between lisdexamfetamine and other drugs used off-label to treat BED are lacking.
  - In 2 Phase 3, 12-week, randomized, DB, PC trials (*McElroy et al 2016*) (N = 773) in patients with moderate to severe BED, lisdexamfetamine-treated patients had a statistically significantly greater reduction from baseline in mean number of binge days per week at week 12 vs placebo (treatment difference in study 1: -1.35; 95% CI, -1.70 to -1.01; study 2: -1.66; 95% CI, -2.04 to -1.28; both p < 0.001).
    - A 12-month, OL extension study (*Gasior et al 2017*) (N = 599) in adults with BED found that the long-term safety and tolerability of lisdexamfetamine were generally consistent with the safety profile observed in 3 previous short-term trials in BED as well as its established profile for ADHD. Common treatment-emergent AEs included dry mouth, headache, insomnia, and upper respiratory tract infection. Weight loss and increases in blood pressure and pulse rate were also observed.

- In a Phase 3, DB, randomized, PC, withdrawal study (*Hudson et al 2017*) (N = 418) in adults with moderate to severe BED, responders to lisdexamfetamine during a 12-week OL phase were randomized to placebo or continued lisdexamfetamine during a 26-week, DB phase. The percentage of patients meeting relapse criteria was 3.7% with lisdexamfetamine vs 32.1% with placebo; time to relapse statistically favored lisdexamfetamine ($p < 0.001$). The hazard ratio (HR) was 0.09 (95% CI, 0.04 to 0.23).
- A systematic review and meta-analysis of 14 clinical and 7 preclinical trials concluded that lisdexamfetamine effectively treats BED and reduces both symptoms (MD, 0.93; 95% CI, 0.74 to 1.12) and body weight (based on systematic review only) (*Schneider et al 2021*).
- A systematic review and meta-analysis of 9 waitlist-controlled psychological trials and 25 PC trials evaluating pharmacologic (n = 19) or combination (n = 6) treatment for BED (*Brownley et al 2016*) found that therapist-led cognitive behavioral therapy (CBT), lisdexamfetamine, and second-generation antidepressants (SGAs) increased binge-eating abstinence (relative risk [RR], 4.95 [95% CI, 3.06 to 8.00], 2.61 [95% CI, 2.04 to 3.33], and 1.67 [95% CI, 1.24 to 2.26], respectively), while lisdexamfetamine and SGAs decreased binge-eating frequency (MD in days/week, -1.35 [95% CI, -1.77 to -0.93] and -0.67 [95% CI, -1.26 to -0.09], respectively). Topiramate and other forms of CBT also increased abstinence and reduced binge-eating frequency.
- A 2018 systematic review and meta-analysis of 45 RCTs (*Ghaderi et al 2018*) compared various psychological, pharmacological, and combined treatments for BED, and found moderate support for the efficacy of CBT and CBT-guided self-help (moderate quality of evidence), and low-quality evidence to support interpersonal psychotherapy, selective serotonin reuptake inhibitors (SSRIs), and lisdexamfetamine for the cessation of or reduction in the frequency of binge eating. Only lisdexamfetamine showed a modest effect on weight loss (SMD for body mass index -5.23; 95% CI, -6.52 to -3.94).

CLINICAL GUIDELINES

ADHD

- Several clinical guidelines have provided recommendations on the treatment of ADHD in children and adolescents.
  - According to the American Academy of Pediatrics (AAP) guidelines (*Wolraich et al 2019*), the evidence is particularly strong for stimulant medications, and sufficient but less strong for atomoxetine, guanfacine ER, and clonidine ER (in that order; newer agents such as serdexmethylphenidate/dexmethylphenidate [Azstarys] and viloxazine [Qelbree] are not addressed in the current guidelines). Guanfacine ER and clonidine ER have evidence to support their use as adjunctive therapy with stimulant medications. Methylphenidate is recommended for preschool-aged children who have had an inadequate response to behavioral interventions.
  - The Society for Developmental and Behavioral Pediatrics guideline on assessment and treatment of children and adolescents with complex ADHD states that treatment should aim to improve functional impairment and include skill development in self-management strategies (*Barbaresi et al 2020*). Multimodal treatment with both behavioral and pharmacologic therapies may be needed. Specific pharmacologic classes are discussed in the context of learning disorder, for which the guideline recommends both stimulants and atomoxetine, with stimulants having a greater strength of evidence, and autism, for which a stimulant is recommended first followed by an alpha$_2$-adrenergic agonist or atomoxetine. Stimulant use is also endorsed in children with intellectual disability, tics, anxiety or depression, and disruptive behavior disorders.
  - The Medical Letter recommends that treatment of ADHD in school-age children or adults should begin with a stimulant, either a methylphenidate- or amphetamine-based formulation (*Med Lett Drugs Ther 2020*). Mixing short- and long-acting stimulants can be helpful to achieve an immediate effect for early-morning school classes or for reducing rebound irritability or overactivity, especially in the evening. Nonstimulants can be used in combination with stimulants or when stimulants are contraindicated, ineffective, or not tolerated.
  - According to the American Academy of Neurology guidelines for treatment of tics (*Pringsheim et al 2019*), physicians should counsel individuals with tics and comorbid ADHD that alpha$_2$-adrenergic agonists may provide benefit for both conditions. Alpha$_2$-adrenergic agonists and topiramate should be prescribed for the treatment of tics when the benefits of treatment outweigh the risks, while antipsychotics and botulinum toxin may be prescribed when the benefits outweigh the risks.
  - The American Academy of Child and Adolescent Psychiatry (AACAP) practice parameter for the treatment of children and adolescents with tic disorders (*Murphy et al 2013*) states that alpha$_2$-adrenergic agonists have demonstrated an effect size of 0.5 for the amelioration of tics and may be preferred by some prescribers over antipsychotics due to their relatively favorable AE profile.

Narcolepsy

- The American Academy of Sleep Medicine (AASM) practice parameters (*Maski et al 2021*) recommend various drugs for the treatment of daytime sleepiness in adults due to narcolepsy including modafinil, pitolisant, sodium oxybate, solriamfetol (strongly recommended), and armodafinil, dextroamphetamine, and methylphenidate (conditionally recommended). Idiopathic hypersomnia in adults should be treated with modafinil (strongly recommended), clarithromycin, methylphenidate, pitolisant, or sodium oxybate (conditionally recommended). Recommended therapies for children with narcolepsy include modafinil and sodium oxybate (both conditionally recommended),

BED

- According to the American Psychiatric Association (APA) practice guidelines on eating disorders (*Yager et al 2006*, *Yager et al 2012* [guideline watch update], now categorized as a legacy guideline), treatment of BED may include the following:
  - Nutritional rehabilitation and counseling
  - Psychosocial treatment
    - CBT, behavior therapy, dialectical behavior therapy (DBT), and interpersonal therapy (IPT) have all been associated with binge frequency reduction rates of 67% or more and significant abstinence rates during active treatment.
    - Self-help programs using self-guided, professionally designed manuals have been effective in reducing the symptoms of BED in the short-run for some patients and may have long-term benefit.
  - Medications
    - Antidepressant treatment is associated with short-term reductions in binge-eating but generally does not result in substantial weight loss. SSRIs have the fewest difficulties with AEs and the most evidence for efficacy when used at the high end of the recommended dose range.
    - Topiramate can reduce bingeing and decrease weight, but its use may be limited by AEs.
  - Combination psychotherapy and pharmacotherapy
    - For most patients, adding antidepressant therapy to a behavioral weight control and/or CBT regimen does not have a significant effect on binge suppression.
    - Although limited evidence is available, combined treatment is frequently used in clinical practice.
- The American Association of Clinical Endocrinologists and the American College of Endocrinology (AACE/ACE) guidelines for medical care of patients with obesity (*Garvey et al 2016*) recommend the following for patients with overweight or obesity who have BED:
  - Patients should be treated with a structured behavioral/lifestyle program, combined with CBT or other psychological interventions
  - Treatment with orlistat or approved medications containing topiramate or bupropion may be considered in conjunction with structured lifestyle therapy, CBT, and/or psychological interventions
- The Task Force on Eating Disorders of the World Federation of Societies of Biological Psychiatry (*Aigner et al 2011*) concluded that for the treatment of BED, grade A evidence supports the use of imipramine (moderate risk-benefit ratio), sertraline (good risk-benefit ratio), citalopram/escitalopram (good risk-benefit ratio), orlistat (low to moderate risk-benefit ratio), and topiramate (moderate risk-benefit ratio). Atomoxetine has grade B evidence supporting its use.

SAFETY SUMMARY

- Due to the potential for abuse, the stimulants are classified as Schedule II controlled substances. Atomoxetine, clonidine ER, guanfacine ER, and viloxazine ER are not classified as controlled substances.
- Various stimulants are contraindicated for use in patients with advanced arteriosclerosis, symptomatic CV disease, moderate to severe hypertension, hyperthyroidism, hypersensitivity to sympathomimetic amines, glaucoma, agitated states, history of drug abuse, tics, and in those using monoamine oxidase inhibitors (MAOIs). The stimulants carry a boxed warning for potential drug abuse and dependence. They also have warnings for increased risks of serious CV reactions, psychiatric AEs, suppression of growth, seizures, visual disturbance, peripheral vasculopathy, and priapism. Amphetamines have a warning for risk of serotonin syndrome when used in combination with other drugs affecting the serotonergic neurotransmitter systems.
  - Common AEs of stimulants include anorexia, decreased weight, tachycardia, anxiety, irritability, and insomnia.
  - Refer to the prescribing information for details on warnings, precautions, and AEs for individual products. For example:
    - QuilliChew ER can be harmful to patients with phenylketonuria (PKU) since it contains phenylalanine.

- Because Concerta and Relexxii tablets are nondeformable and do not appreciably change in shape in the gastrointestinal tract, they should not ordinarily be administered to patients with preexisting severe gastrointestinal narrowing.
- The use of Daytrana and Xelstrym may lead to contact sensitization; in addition, exposure of the application site to external heat sources should be avoided due to increased absorption of the drug. Daytrana use may result in chemical leuokoderma.
- Adhansia XR capsules contain FD&C yellow No. 5 dye (tartrazine), which may cause allergic-type reactions in susceptible patients.

- Atomoxetine is contraindicated for use in patients with narrow angle glaucoma, pheochromocytoma, severe CV disorders, hypersensitivity to any component of the product, and in those taking MAOIs. It carries a boxed warning for a rare increased risk of suicidal ideation in children and adolescents. It also has warnings for serious CV events, effects on blood pressure and heart rate, effects on growth, psychotic or manic symptoms, aggressive behavior or hostility, rare cases of severe liver injury, urinary retention, and priapism. Patients should be screened for a personal or family history of bipolar disorder prior to use of atomoxetine due to the risk of activation of mania or hypomania.
  - Common AEs associated with atomoxetine include somnolence, nausea, and vomiting.
- Viloxazine ER is contraindicated with concurrent use of MAOIs and sensitive CYP1A2 substrates or CYP1A2 substrates with a narrow therapeutic index. Viloxazine ER carries a boxed warning for suicidal thoughts and behavior in patients treated with the drug. It also has warnings for effects on heart rate and blood pressure and the potential for somnolence and fatigue. Patients should be screened for bipolar disorder prior to use of viloxazine ER due to the risk of activation of mania or hypomania.
  - Common AEs associated with viloxazine ER include somnolence, nausea, and vomiting.
- The alpha$_2$-adrenergic agonists are contraindicated in patients known to be hypersensitive to any constituent of the product. They carry warnings for increased risk of hypotension, bradycardia, and syncope; sedation and somnolence; rebound hypertension; and cardiac conduction abnormalities.
  - Common AEs associated with clonidine ER include somnolence, fatigue, and irritability while common AEs with guanfacine ER include somnolence, fatigue, and hypotension.

DOSING AND ADMINISTRATION

Table 4. Dosing and Administration

Drug	Duration of action*	Available Formulations	Route	Usual Recommended Frequency	Comments
Stimulants					
Evekeo (amphetamine)	4 to 6 h	Tablets	Oral	*ADHD, narcolepsy*: Daily up to divided doses daily *Exogenous obesity*: Divided doses daily	*ADHD and narcolepsy* The first dose should be given upon awakening; additional doses at intervals of 4 to 6 hours.
Evekeo ODT (amphetamine)	4 to 6 h	Orally disintegrating tablets	Oral	Once or twice daily in the morning	As soon as the blister pack is opened, the tablet should be placed on the patient's tongue and allowed to disintegrate without chewing or crushing. The tablet will disintegrate in saliva so that it can be swallowed.

Drug	Duration of action*	Available Formulations	Route	Usual Recommended Frequency	Comments
Adzenys XR-ODT (amphetamine ER)	10 to 12 h	Orally disintegrating tablets	Oral	Daily in the morning	As soon as the blister pack is opened, the tablet should be placed on the patient's tongue and allowed to disintegrate without chewing or crushing. The tablet will disintegrate in saliva so that it can be swallowed.
Dyanavel XR (amphetamine ER)	Up to 13 h	Suspension, ER tablets	Oral	Daily in the morning	The bottle should be shaken before administration. ER tablets may be chewed or swallowed whole. The 5 mg tablet may be split along the score line.
Adderall (mixed amphetamine salts)	4 to 6 h	Tablets	Oral	*ADHD, narcolepsy*: Daily up to divided doses daily	The first dose should be given on awakening, then additional doses at intervals of 4 to 6 hours.
Adderall XR (mixed amphetamine salts ER)	10 to 12 h	Capsules	Oral	Daily in the morning	Capsules may be taken whole, or the capsule may be opened and the entire contents sprinkled on applesauce and consumed immediately. The dose of a single capsule should not be divided.
Mydayis (mixed amphetamine salts ER)	16 h	Capsules	Oral	Daily in the morning	Dosage adjustment is needed for severe renal impairment. Use in end stage renal disease (ESRD) is not recommended. Capsules may be taken whole, or the

Drug	Duration of action*	Available Formulations	Route	Usual Recommended Frequency	Comments
					capsule may be opened and the entire contents sprinkled on applesauce and consumed immediately in its entirety without chewing. The dose of a single capsule should not be divided.
Focalin (dexmethylphenidate)	3 to 5 h	Tablets	Oral	Twice daily	Separate doses by at least 4 hours.
Focalin XR (dexmethylphenidate ER)	8 to 12 h	Capsules	Oral	Daily in the morning	ER capsules may be taken whole, or the capsule may be opened and the entire contents sprinkled on applesauce and consumed immediately in its entirety without chewing. The dose of a single capsule should not be divided.
ProCentra, Zenzedi (dextroamphetamine)	4 to 6 h	Solution (ProCentra) Tablets (Zenzedi)	Oral	*ADHD, narcolepsy*: Daily up to divided doses daily	The first dose should be given upon awakening; additional doses at intervals of 4 to 6 hours
Dexedrine Spansule (dextroamphetamine SR)	6 to 8 h	Capsules	Oral	*ADHD* Daily or twice daily Narcolepsy Daily	
Xelstrym (dextroamphetamine transdermal system)	Up to 12 h	Transdermal system	Transdermal	The patch should be applied 2 hours before an effect is needed and removed within 9 hours.	Dose titration and final dosage should be individualized depending on clinical response and tolerability. Dosage adjustment is needed for renal impairment/ESRD.

Drug	Duration of action*	Available Formulations	Route	Usual Recommended Frequency	Comments
Vyvanse (lisdexamfetamine)	10 to 12 h	Capsules, chewable tablets	Oral	*ADHD, BED*: Daily in the morning	Dosage adjustment is needed for renal impairment/ESRD. The capsules may be swallowed whole or can be opened, emptied, and mixed with yogurt, water, or orange juice and consumed immediately. A single capsule should not be divided. The chewable tablets must be chewed thoroughly before swallowing. A single dose should not be divided.
Desoxyn (methamphetamine)	4 to 5 h	Tablets	Oral	Daily to twice daily	
Methylin, Ritalin (methylphenidate)	3 to 5 h	Chewable tablets, tablets (Ritalin), solution (Methylin)	Oral	Twice daily to 3 times daily	The chewable tablets should be taken with at least 8 ounces (a full glass) of water or other fluid. The liquid and chewable tablets should be given 30 to 45 minutes before meals. The ER tablets may be used in place of the IR tablets when the 8-hour dosage of the ER product corresponds to the titrated 8-hour dosage of the IR products. The ER tablets must be swallowed
Methylphenidate ER	8 h	Tablets			

Drug	Duration of action*	Available Formulations	Route	Usual Recommended Frequency	Comments
					whole and never crushed or chewed.
Adhansia XR (methylphenidate ER)	13 h	Capsules	Oral	Daily in the morning	The capsules may be taken whole or they can be opened and sprinkled onto applesauce or yogurt; the entire contents of the mixture should be consumed within 10 minutes, and should not be chewed. The dose of a single capsule should not be divided.
Aptensio XR (methylphenidate ER)	12 h	Capsules	Oral	Daily in the morning	The capsules may be taken whole or they can be opened and sprinkled onto applesauce; the applesauce should be consumed immediately and it should not be chewed. The dose of a single capsule should not be divided.

Drug	Duration of action*	Available Formulations	Route	Usual Recommended Frequency	Comments
Concerta (methylphenidate ER)	12 h	Tablets	Oral	Daily in the morning	The tablets should not be chewed or crushed. Note: An FDA analysis of methylphenidate ER products manufactured by UCB/Kremers (formerly Kudco) and Mallinckrodt indicated that in some individuals, they may deliver the drug in the body at a slower rate during the 7- to 12-hour range. As a result, the FDA changed the therapeutic equivalence of these products from AB to BX. Because these manufacturers have subsequently failed to demonstrate that their products are bioequivalent to the brand-name reference drug, the FDA proposed to withdraw their approval (*FDA 2016*).
Methylphenidate ER					
Cotempla XR-ODT (methylphenidate ER)	12 h	Orally disintegrating tablets	Oral	Daily in the morning	As soon as the blister pack is opened, the tablet should be placed on the patient's tongue and allowed to disintegrate without chewing or crushing. The tablet will disintegrate in saliva so that it can be swallowed.

Drug	Duration of action*	Available Formulations	Route	Usual Recommended Frequency	Comments
Jornay PM (methylphenidate ER)	10 h	Capsules	Oral	Daily in the evening	The capsule may be swallowed whole or it may be opened and the contents sprinkled onto applesauce and given immediately. The capsule contents must not be crushed or chewed, the dose of a single capsule should not be divided, and the contents of the entire capsule should be taken at the same time.
Methylphenidate ER (CD)	6 to 9 h	Capsules	Oral	Daily in the morning	The capsule may be swallowed whole or it may be opened and the contents sprinkled onto a small amount (one tablespoon) of applesauce and given immediately, followed by some fluids. The capsule contents must not be crushed or chewed.
QuilliChew ER (methylphenidate ER)	8 h	Chewable tablets	Oral	Daily in the morning	A 10 mg or 15 mg dose can be achieved by breaking in half the functionally scored 20 mg and 30 mg tablets, respectively.
Quillivant XR (methylphenidate ER)	12 h	Suspension	Oral	Daily in the morning	The bottle of Quillivant XR should be shaken vigorously for 10 seconds prior to administration. The suspension is stable for up to 4

Drug	Duration of action*	Available Formulations	Route	Usual Recommended Frequency	Comments
					months once reconstituted.
Relexxii (methylphenidate ER 72 mg)	12 h	Tablet	Oral	Daily in the morning	The tablet must be swallowed whole with the aid of liquids, and must not be chewed, divided, or crushed.
Ritalin LA (methylphenidate ER)	6 to 9 h	Capsules	Oral	Daily in the morning	The capsule may be swallowed whole or may be administered by sprinkling the capsule contents on a small amount of applesauce; the contents should not be crushed, chewed, or divided. The mixture should be consumed immediately.
Daytrana (methylphenidate transdermal system)	Up to 12 h	Transdermal system	Transdermal	The patch should be applied 2 hours before an effect is needed and removed within 9 hours. It may be removed earlier than 9 hours if a shorter duration of effect is desired or late day side effects appear.	
Azstarys (serdexmethylphenidate/ dexmethylphenidate)	10 to 13 h	Capsules	Oral	Daily in the morning	The capsule may be swallowed whole or may be administered by sprinkling the capsule contents over 2 tablespoons of applesauce or 50 mL of water. The mixture should be consumed immediately.
Non-stimulants					
Strattera (atomoxetine)	At least 10 to 12 h	Capsules	Oral	Daily in the morning or	Dosage adjustment is recommended for

Drug	Duration of action*	Available Formulations	Route	Usual Recommended Frequency	Comments
				divided dose in the morning and late afternoon/ early evening	patients with moderate or severe hepatic insufficiency, for use with strong CYP2D6 inhibitors, and for patients known to be CYP2D6 poor metabolizers. The capsules are not intended to be opened and should be taken whole.
Kapvay (clonidine ER)	At least 10 to 12 h	Tablets	Oral	Daily at bedtime or twice daily divided doses	With twice daily dosing, either an equal or higher split dosage should be given at bedtime. The tablets should not be crushed, chewed, or broken prior to swallowing. The initial dosage should be based on the degree of renal impairment.
Intuniv (guanfacine ER)	At least 8 to 12 h	Tablets	Oral	Daily in the morning or evening	The tablets should not be crushed, chewed, or broken prior to swallowing; they should not be administered with high fat meals, due to increased exposure. It may be necessary to reduce the dosage in patients with significant renal and hepatic impairment.
Qelbree (viloxazine ER)	Throughout the day (specific duration	Capsules	Oral	Daily	The capsule may be swallowed whole or may be administered by

Drug	Duration of action*	Available Formulations	Route	Usual Recommended Frequency	Comments
	not reported)				sprinkling the capsule contents over a teaspoon of applesauce. The mixture should be consumed within 2 hours, without chewing.

See the current prescribing information for full details
*References: Prescribing information for individual products, *Medical Letter 2020, Pharmacist's Letter 2021, Krull 2022d.*

CONCLUSION

- Both CNS stimulants and nonstimulants may be used for the treatment of ADHD. In general, stimulants are first-line treatment due to their superior efficacy. Clinical evidence suggests that methylphenidate and amphetamines are equally efficacious, but some patients may respond to one stimulant and not the other. Various short-, intermediate- and long-acting formulations (eg, tablets/capsules, chewable/orally disintegrating tablets, solution/suspension, transdermal patch) are available to provide a range of dosing options. Although nonstimulants such as atomoxetine and alpha$_2$-adrenergic agonists have smaller effect sizes, they may be used in patients who have failed or are intolerant to stimulants or when there is concern about possible abuse or diversion. The efficacy of the nonstimulant viloxazine ER in comparison to other nonstimulants is unknown. The alpha$_2$-adrenergic agonists are approved both as monotherapy and as adjunctive therapy to stimulants, and they have been shown to improve both tic and ADHD symptoms in patients with comorbid tic disorder.
  - Current consensus clinical guidelines for the treatment of children and adolescents with ADHD recommend that stimulants are highly effective for reducing core symptoms of ADHD in children (*Wolraich et al 2019*).
- Ultimately, the choice of the initial agent for treatment of ADHD depends upon various factors such as: duration of desired coverage; ability of the child to swallow pills; coexisting tic disorder (use of alpha$_2$-adrenergic agonists may be warranted); potential AEs, history of substance abuse in the patient or household member (eg, avoid stimulants or use stimulants with less potential for abuse [eg, lisdexamfetamine, osmotic-release preparation, methylphenidate patch]); and preference of the patient and parent/guardian (*Krull 2022b*).
- Various stimulants are indicated for treatment of narcolepsy and are generally considered to be second-line agents after modafinil/armodafinil due to their sympathomimetic AEs (*Scammell 2021*).
- Lisdexamfetamine is the only FDA-approved drug indicated for the treatment of moderate to severe BED, with demonstrated efficacy in reduction of mean binge days per week vs placebo. Direct comparison trials between lisdexamfetamine and other drugs used off-label to treat BED are lacking.

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