DUR Board Meeting
December 6, 2017
Heritage Center
Lecture Rooms A & B

north dakota
department of
human services

North Dakota Medicaid
DUR Board Meeting Agenda
Brynhild Haugland Room
State Capitol
600 East Boulevard Avenue
Bismarck, ND
December 6, 2017
1:00 pm

1. Administrative items
    - Travel vouchers

2. Old business
    - Review and approval of 09/06/2017 meeting minutes
    - Budget update
    - Review top 15 therapeutic categories/top 25 drugs
    - Prior authorization/PDL update
    - Annual prior authorization review of forms and criteria

3. New business
    - Input regarding opioid and benzodiazepine abuse and overdose diagnoses
    - Review of Eucrisa
    - Review of Skelaxin
    - Criteria recommendations
    - Upcoming meeting date/agenda

4. Adjourn

Please remember to silence all cellular phones during the meeting.

Drug Utilization Review (DUR) Meeting Minutes

September 6, 2017

Members Present: Tanya Schmidt, Laura Schield, Jeffrey Hostetter, Michael Quast, Zach Marty, LeNeika Roehrich, Andrea Honeyman, Carlotta McCleary,

Members Absent: Michael Booth, Peter Woodrow, Gaylord Kavlie, Katie Kram, Wendy Brown,

Medicaid Pharmacy Department: Brendan Joyce, Alexi Murphy

Old Business

L. Roehrich served as Chair in the absence of W. Brown, and called the meeting to order at 1:00 p.m. Chair L. Roehrich asked for a motion to approve the minutes of the September meeting. L. Schield moved that the minutes be approved and Z. Marty seconded the motion. Chair L. Roehrich called for a voice vote to approve the minutes. The motion passed with no audible dissent.

Review Top 15 Therapeutic Categories/Top 25 Drugs

B. Joyce presented the quarterly review of the top 15 therapeutic classes by total cost of claims, top 25 drugs based on number of claims, and top 25 drugs based on claims cost for the 2nd quarter of 2017.

Sanford Update

Danny Weiss, representing Sanford Health Plan, spoke regarding ND Medicaid Expansion. In 2016, there were 19,506 average members per month with 102.2% of members utilizing benefits. The generic fill rate was 85.9%. The top 25 drugs represent 42.1% of total plan cost and 8 of the top 25 drugs are specialty drugs. The top 10 indications by cost represent 70.4% of total plan costs with the largest trend being in inflammatory conditions with a 71.5% increase from 2015.

Second Reviews

A motion and second was made at the June meeting to place Biltricide and Procysbi on prior authorization. The topics were brought up for a second review. There was no public comment. The motion to place Biltricide and Procysbi on prior authorization passed with no audible dissent.

PDL Update

A. Murphy shared with the Board all of the recommended PDL changes since the last 2017 version of the PDL was posted. Added to PA required were Kevzara to the Cytokine Modulators criteria, Morphabond ER to the Narcotics criteria, Ellzia Pak to the Kit criteria, Fabior to the Acne criteria, Brovana to the COPD criteria, Lialda and Apriso to the Inflammatory Bowel Agents criteria, Prednisolone sodium phosphate 10 mg/5 mL and 20 mg/5 mL to the Prednisolone Non-Solid Oral Dosage Forms criteria, Methyltest and methyltestosterone to the Oral Testosterone criteria, and Ilaris and Tymlos to the medications >$3,000 criteria. Xolair, Brineuria, and Ketamine were added to the Medical Billing Only list of medications, and Xifaxan 550 mg, Avonex, and Avonex pen will no longer require PA.

New Business

Juxtapid and Kynamro

B. Joyce presented updated criteria and a drug specific form for Juxtapid and Kynamro for the Board to review. There was no public comment. The motion to approve the updated criteria and form passed with no audible dissent.

Procysbi

B. Joyce presented updated criteria and a drug specific form for Procysbi for the Board to review. There was no public comment. The motion to approve the updated criteria and form passed with no audible dissent.

Tymlos and Miacalcin

B. Joyce presented updated criteria and a drug specific form for Tymlos and Miacalcin for the Board to review. There was no public comment. The motion to approve the updated criteria and form passed with no audible dissent.

Tardive Dyskinesia Agents

B. Joyce and A. Murphy presented updated criteria and a drug specific form for agents used to treat of tardive dyskinesia including Austedo, Ingrezza, and tetrabenazine. Maggie Murphy, representing Teva Pharmaceuticals, offered the opportunity to ask any questions regarding Austedo. Samantha Cicero, representing Neurocrine Biosciences, presented product information regarding Ingrezza. Z. Marty and L. Schield proposed amending the criteria for Ingrezza to require a trial of Austedo as opposed to a trial of tetrabenazine. The motion to approve the amended updated criteria and form passed with no audible dissent.

Jadenu

B. Joyce and A. Murphy presented updated criteria and a drug specific form for Jadenu for the Board to review. There was no public comment. The motion to approve the updated criteria and form passed with no audible dissent.

Review of Opioid Analgesic and Benzodiazepine Utilization

B. Joyce presented data showing current utilization of benzodiazepines, including use with and without opioid analgesics, rate of appropriate utilization for a diagnosis of anxiety, and utilization of multiple benzodiazepines. B. Joyce presented data showing utilization of opioid analgesics, including historic and current utilization of each individual agent by prescription count and average dose. The Board discussed potential provider education and drug edit opportunities.

Physician Prescribing Patterns for Select Therapeutic Categories

B. Joyce presented data showing the top prescriber utilization of select medications in therapeutic drug classes in order to evaluate utilization trends and potential outliers. Therapeutic classes evaluated included opioid analgesics, benzodiazepines, and gabapentin. Prescriber utilization was presented as number of prescriptions for, and patients currently on, selected medications, percent utilization of selected medications within their therapeutic class, and those with the highest number of patients on a high dose of select mediations.

Review of Stimulant Utilization Trends

B. Joyce presented stimulant utilization data trends over time, from 2001 to 2017. The data tracked the average daily dose per patient of each individual medication by age group. The data trends predominantly revealed increase in average daily dose overall with some exceptions in some age groups trending towards a dose decrease.

Criteria Recommendations

The recommended RDUR criteria enclosed in the packet were developed from product information provided by the manufacturers and are usually consistent with new indications, new drugs added, and new warnings. These proposed criteria will be added to the current set of criteria and will be used in future DUR cycles. J. Hostetter moved to approve the new criteria and Z. Marty seconded the motion. The motion passed with no audible dissent. The next DUR Board meeting will be held December 6, 2017 at the Capitol in the Brynhild Haugland room in Bismarck. L. Roehrich adjourned the meeting.

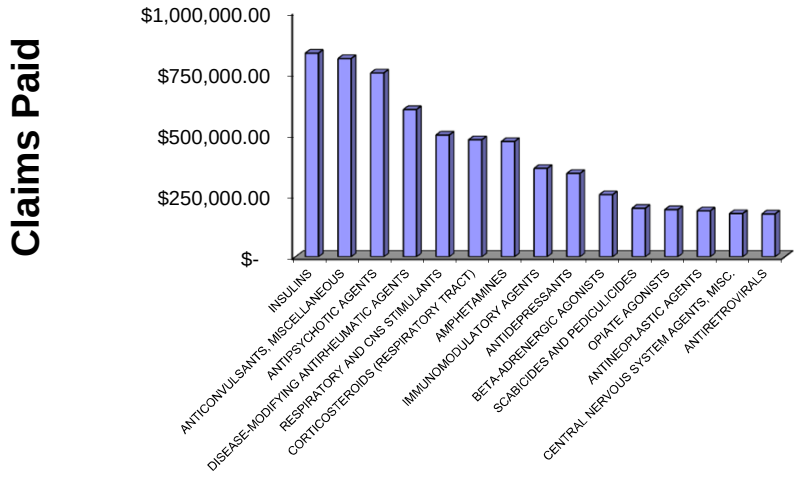
NORTH DAKOTA MEDICAID
Cost Management Analysis

TOP 15 THERAPEUTIC CLASSES BY TOTAL COST OF CLAIMS FROM 07/01/2017 - 09/30/2017

AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
INSULINS	1,863	$ 831,863.50	$ 446.52	1.35%
ANTICONVULSANTS, MISCELLANEOUS	8,445	$ 809,726.20	$ 95.88	6.10%
ANTIPSYCHOTIC AGENTS	5,899	$ 751,014.15	$ 127.31	4.26%
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	159	$ 602,010.53	$ 3,786.23	0.11%
RESPIRATORY AND CNS STIMULANTS	3,619	$ 498,088.18	$ 137.63	2.61%
CORTICOSTEROIDS (RESPIRATORY TRACT)	1,974	$ 478,880.05	$ 242.59	1.43%
AMPHETAMINES	3,349	$ 471,604.96	$ 140.82	2.42%
IMMUNOMODULATORY AGENTS	59	$ 361,574.73	$ 6,128.39	0.04%
ANTIDEPRESSANTS	14,568	$ 341,037.59	$ 23.41	10.53%
BETA-ADRENERGIC AGONISTS	3,426	$ 254,195.62	$ 74.20	2.48%
SCABICIDES AND PEDICULICIDES	781	$ 198,681.88	$ 254.39	0.56%
OPIATE AGONISTS	5,550	$ 193,180.55	$ 34.81	4.01%
ANTINEOPLASTIC AGENTS	237	$ 188,027.54	$ 793.37	0.17%
CENTRAL NERVOUS SYSTEM AGENTS, MISC.	1,584	$ 176,965.92	$ 111.72	1.14%
ANTIRETROVIRALS	176	$ 175,458.24	$ 996.92	0.13%
Total Top 15	51,689	$ 6,332,309.64	$ 122.51	37.35%

Total Rx Claims From 07/01/2017 - 09/30/2017	138,397

Top 15 Therapeutic Classes
Based on Total Cost of Claims

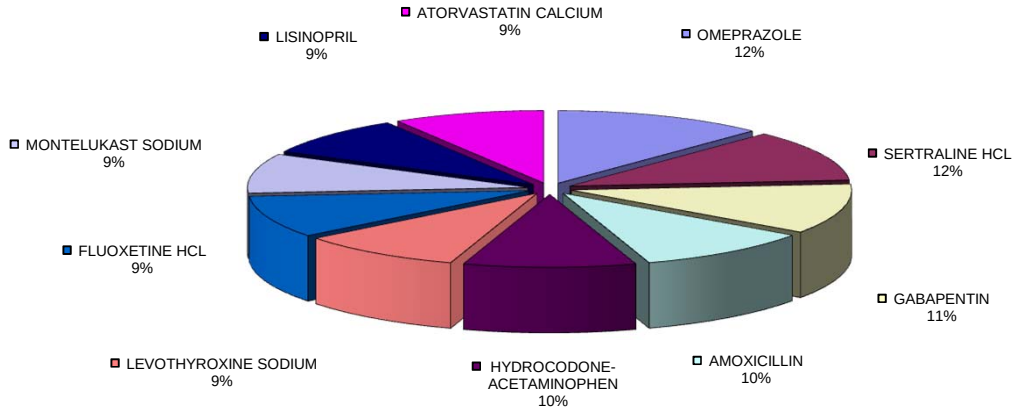


TOP 25 DRUGS BASED ON NUMBER OF CLAIMS FROM 07/01/2017 - 09/30/2017

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
OMEPRAZOLE	PROTON-PUMP INHIBITORS	2,671	$ 49,257.58	$ 18.44	1.93%
SERTRALINE HCL	ANTIDEPRESSANTS	2,510	$ 44,802.97	$ 17.85	1.81%
GABAPENTIN	ANTICONVULSANTS, MISCELLANEOUS	2,433	$ 78,781.18	$ 32.38	1.76%
AMOXICILLIN	PENICILLINS	2,242	$ 93,546.06	$ 41.72	1.62%
HYDROCODONE-ACETAMINOPHEN	OPIATE AGONISTS	2,172	$ 74,809.13	$ 34.44	1.57%
LEVOTHYROXINE SODIUM	THYROID AGENTS	2,067	$ 42,246.09	$ 20.44	1.49%
FLUOXETINE HCL	ANTIDEPRESSANTS	2,043	$ 33,334.49	$ 16.32	1.48%
MONTELUKAST SODIUM	LEUKOTRIENE MODIFIERS	1,922	$ 32,045.07	$ 16.67	1.39%
LISINOPRIL	ANGIOTENSIN-CONVERTING ENZYME INHIBITORS	1,913	$ 41,629.87	$ 21.76	1.38%
ATORVASTATIN CALCIUM	HMG-COA REDUCTASE INHIBITORS	1,910	$ 45,939.44	$ 24.05	1.38%
TRAZODONE HCL	ANTIDEPRESSANTS	1,846	$ 26,941.66	$ 14.59	1.33%
METHYLPHENIDATE ER	RESPIRATORY AND CNS STIMULANTS	1,656	$ 316,725.42	$ 191.26	1.20%
METFORMIN HCL	BIGUANIDES	1,452	$ 23,481.82	$ 16.17	1.05%
CLONIDINE HCL	CENTRAL ALPHA-AGONISTS	1,447	$ 20,893.72	$ 14.44	1.05%
BUPROPION XL	ANTIDEPRESSANTS	1,389	$ 34,188.45	$ 24.61	1.00%
ESCITALOPRAM OXALATE	ANTIDEPRESSANTS	1,388	$ 22,682.68	$ 16.34	1.00%
VYVANSE	AMPHETAMINES	1,353	$ 280,973.81	$ 207.67	0.98%
QUETIAPINE FUMARATE	ANTIPSYCHOTIC AGENTS	1,311	$ 22,307.76	$ 17.02	0.95%
RISPERIDONE	ANTIPSYCHOTIC AGENTS	1,287	$ 18,803.20	$ 14.61	0.93%
CETIRIZINE HCL	SECOND GENERATION ANTIHISTAMINES	1,231	$ 42,322.64	$ 34.38	0.89%
FLUTICASONE PROPIONATE	CORTICOSTEROIDS (EENT)	1,187	$ 21,656.60	$ 18.24	0.86%
PROAIR HFA	BETA-ADRENERGIC AGONISTS	1,176	$ 80,090.02	$ 68.10	0.85%
LAMOTRIGINE	ANTICONVULSANTS, MISCELLANEOUS	1,171	$ 22,291.35	$ 19.04	0.85%
IBUPROFEN	NONSTEROIDAL ANTI-INFLAMMATORY AGENTS	1,161	$ 51,897.46	$ 44.70	0.84%
CLONAZEPAM	BENZODIAZEPINES (ANTICONVULSANTS)	1,160	$ 26,731.46	$ 23.04	0.84%
TOTAL TOP 25		42,098	$ 1,548,379.93	$ 36.78	30.42%

Total Rx Claims From 07/01/2017 - 09/30/2017	138,397

Top 10 Drugs
Based on Number of Claims

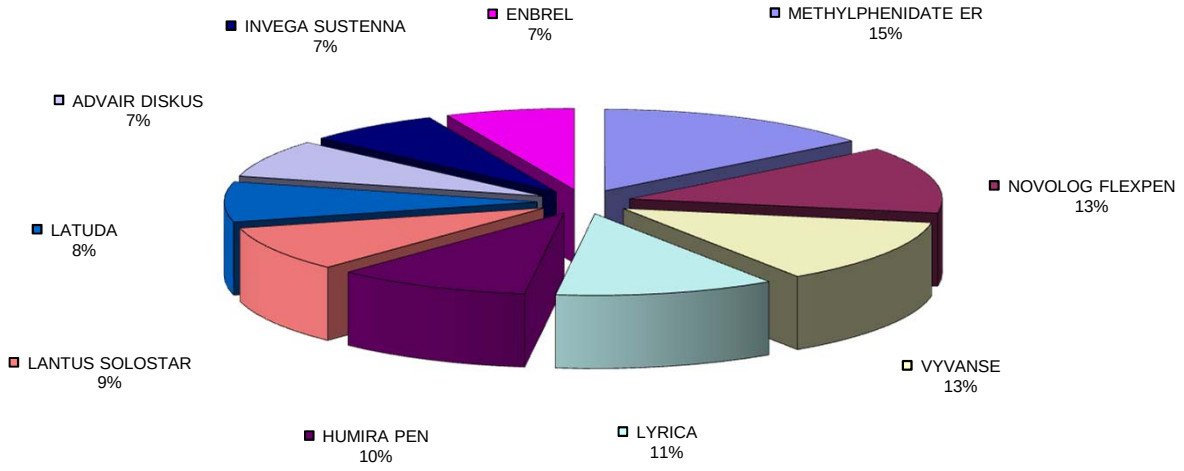


TOP 25 DRUGS BASED ON TOTAL CLAIMS COST FROM 07/01/2017 - 09/30/2017

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
METHYLPHENIDATE ER	RESPIRATORY AND CNS STIMULANTS	1,656	$ 316,725.42	$ 191.26	1.20%
NOVOLOG FLEXPEN	INSULINS	571	$ 289,827.47	$ 507.58	0.41%
VYVANSE	AMPHETAMINES	1,353	$ 280,973.81	$ 207.67	0.98%
LYRICA	ANTICONVULSANTS, MISCELLANEOUS	582	$ 248,176.36	$ 426.42	0.42%
HUMIRA PEN	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	54	$ 220,026.35	$ 4,074.56	0.04%
LANTUS SOLOSTAR	INSULINS	502	$ 195,418.02	$ 389.28	0.36%
LATUDA	ANTIPSYCHOTIC AGENTS	213	$ 173,357.04	$ 813.88	0.15%
ADVAIR DISKUS	CORTICOSTEROIDS (RESPIRATORY TRACT)	502	$ 163,415.01	$ 325.53	0.36%
INVEGA SUSTENNA	ANTIPSYCHOTIC AGENTS	81	$ 150,399.84	$ 1,856.79	0.06%
ENBREL	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	42	$ 145,568.25	$ 3,465.91	0.03%
FREESTYLE LITE STRIPS	DIABETES MELLITUS	909	$ 130,569.01	$ 143.64	0.66%
SABRIL	ANTICONVULSANTS, MISCELLANEOUS	9	$ 129,026.33	$ 14,336.26	0.01%
STRATTERA	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	363	$ 128,790.88	$ 354.80	0.26%
COPAXONE	IMMUNOMODULATORY AGENTS	18	$ 117,938.72	$ 6,552.15	0.01%
LEVEMIR FLEXTOUCH	INSULINS	351	$ 107,950.13	$ 307.55	0.25%
ADDERALL XR	AMPHETAMINES	548	$ 107,005.88	$ 195.27	0.40%
GILENYA	IMMUNOMODULATORY AGENTS	15	$ 105,537.66	$ 7,035.84	0.01%
VIMPAT	ANTICONVULSANTS, MISCELLANEOUS	180	$ 101,320.48	$ 562.89	0.13%
PROVENTIL HFA	BETA-ADRENERGIC AGONISTS	1,055	$ 98,659.50	$ 93.52	0.76%
HUMIRA	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	24	$ 96,868.72	$ 4,036.20	0.02%
NIX	SCABICIDES AND PEDICULICIDES	282	$ 96,771.24	$ 343.16	0.20%
AMOXICILLIN	PENICILLINS	2,242	$ 93,546.06	$ 41.72	1.62%
ONFI	BENZODIAZEPINES (ANTICONVULSANTS)	97	$ 91,824.90	$ 946.65	0.07%
SPIRIVA	ANTIMUSCARINICS/ANTISPASMODICS	289	$ 85,741.78	$ 296.68	0.21%
NORDITROPIN FLEXPRO	PITUITARY	24	$ 84,724.14	$ 3,530.17	0.02%
TOTAL TOP 25		11,962	$ 3,760,163.00	$ 314.34	8.64%

Total Rx Claims From 07/01/2017 - 09/30/2017	138,397

Top 10 Drugs
Based on Total Claims Cost



Prior Authorization/PDL Update

Added to PA	Category
ARMONAIR RESPICLICK	Steroid Inhalers
BENLYSTA	> 3000
BILTRICIDE	Biltricide
CLOBETASOL EMOLLIENT FOAM	Topical Psoriatic Arthritis
CLOBETASOL PROPIONATE FOAM	Topical Psoriatic Arthritis
FIASP	Insulins
FIASP FLEXTOUCH	Insulins
HAEGARDA	Hereditary Angioedema
HUMALOG JUNIOR KWIKPEN	Insulins
HYDROCODONE-IBUPROFEN	Narcotics
INGREZZA	Tardive Dyskinesia
LOTEMAX GEL DROPS	OPHTHALMIC ANTIINFLAMMATORIES
MAVYRET	Hep C
ORENITRAM ER	Pulmonary Arterial Hypertension
PROGLYCEM	Proglycem
QVAR REDIHALER	Inhaled Steroids
SYMPROIC	IBS/OIC
SYNDROS	Marinol
TRELEGY ELLIPTA	COPD
TREMFYA	Cytokine Modulators
VOSEVI	Hep C

Removed from PA	Category
MOVIPREP	Bowel Prep Agents

Bill Medical Side VIA 837I AND 837P TRANSACTIONS
BRINEURA
KETAMINE
KYMRIAH
PARSABIV
RENFLEXIS
XIAFLEX

ACTINIC KERATOSIS PA FORM

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Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Solaraze, Zyclara, or Picato must first try imiquimod.

- ***Imiquimod does not require prior authorization***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ ZYCLARA □ SOLARAZE □ PICATO	**Diagnosis for this Request:**		
Physician Signature		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

ALTEPLASE
PA FORM

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855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Alteplase must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Alteplase is indicated for restoration of function to central venous access devices as assessed by the ability to withdraw blood.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ ALTEPLASE	**Diagnosis for this Request:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
DRUG	NDC #
TELEPHONE NUMBER	FAX NUMBER

AMRIX PA FORM

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For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Amrix must try and fail generic cyclobenzaprine.

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

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ AMRIX	**Diagnosis for this request:**		

Qualifications for coverage:

Failed Cyclobenzaprine Therapy? □ YES □ NO	Start Date	End Date	Dose	Frequency

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

ANTIHEMOPHILIC FACTORS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for antihemophilic factors must provide the following information:

- **Visit once per year with an accredited Hemophilia Treatment Center**
- **Date of last appointment with treatment center**
- **Contact information for treatment center**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**Diagnosis for this Request:**
TREATMENT CENTER CONTACT INFORMATION:	**DATE OF LAST APPOINTMENT WITH TREATMENT CENTER:**
	Patient visits an accredited Hemophilia Treatment Center for yearly checkups: □ YES □ NO

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

ANTIHISTAMINE PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving antihistamines must use loratadine (Claritin generic) and cetirizine (Zyrtec generic) as step therapy.

Note:

- **Loratadine OTC and cetirizine OTC (or prescription) may be prescribed WITHOUT prior authorization.**
- **Patient must have failed a 14 day trial of Xyzal OTC, as evidenced by paid pharmacy claims or pharmacy print-outs.**
- **Patient must have failed a 14 day trial of one of the following, as evidenced by paid pharmacy claims or pharmacy print-outs:**
  - **Loratadine OTC**
  - **Cetirizine OTC**

Part I: TO BE COMPLETED BY PRESCRIBER

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	
PRESCRIBER NAME:	PRESCRIBER MEDICAID ID NUMBER:
Address:	Phone: ( )
City:	FAX: ( )
State: Zip:	
REQUESTED DRUG:	**Requested Dosage:** **Diagnosis for this request:**

Qualifications for coverage:

□ Failed loratadine □ Failed cetirizine □ Failed Xyzal OTC	Start Date:	End Date:

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Short-Acting HFA Beta$_2$ Agonist PA FORM

health information designs

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for ProAir RespiClick, Ventolin HFA, or Xopenex HFA must use Proventil HFA as first line therapy.

*__Note: Proventil HFA does not require a prior authorization.__

- **Ventolin HFA – trial of Proventil HFA.**
- **Xopenex HFA – trial of Proventil HFA and Ventolin HFA.**
- **ProAir RespiClick – trial of Proventil HFA, Ventolin HFA, and Xopenex HFA.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ XOPENEX HFA □ VENTOLIN HFA □ PROAIR RESPICLICK	**Diagnosis for this request:**		

Qualifications for coverage:

Failed therapy	Start Date	End Date	Dose	Frequency
1. 2. 3.				

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Prior Authorization Vendor for ND Medicaid

Brisdelle
PA Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Brisdelle must meet the following criteria:

- **Patient must have had a 30-day trial of generic paroxetine.**
- **Patient must have a diagnosis of moderate to severe vasomotor symptoms associated with menopause**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ BRISDELLE	**Diagnosis for Request:** □ Moderate to severe vasomotor symptoms associated with menopause □ Other:		

Qualifications for Coverage:

Medications patient has tried:	Start Date:	End Date:	Dose:	Frequency:

Other medical justification for use:	
Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

health information designs

Prior Authorization Vendor for ND Medicaid

LONG ACTING OPIOID ANALGESICS PA FORM

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

ND Medicaid requires that patients receiving a short-acting opioid analgesic must meet the following criteria:

- **Failure of a 30-day trial of two preferred agents will be required before a non-preferred will be authorized. Oxycodone IR**
- **The prescriber must confirm that they have reviewed the North Dakota PDMP reports for the patient.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**Diagnosis for this Request:** □ Cancer Pain □ Other:
Has patient required daily use of opioids for at least 90 days?	□ YES □ NO
Does the prescriber routinely check the PDMP system?	□ YES □ NO

FAILED THERAPY	**START DATE**	**END DATE**	**DOSE & FREQUENCY**

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

ORAL ANTICOAGULANTS
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

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

- **Patient must have an FDA approved indication.**
- **A 30 day trial of all preferred agents will be required before a non-preferred agent will be authorized.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ PRADAXA □ XARELTO □ ELIQUIS □ SAVAYSA	**Diagnosis for this Request:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Prior Authorization Vendor for ND Medicaid

SHORT ACTING OPIOID ANALGESICS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a short-acting opioid analgesic must meet the following criteria:

- **Subsys, Fentora, Lazanda, Actiq and Abstral**
  - Patient must be at least 18 years of age for Subsys, Fentora, or Lazanda, and 16 years for Actiq or Abstral.
  - The patient must have cancer pain.
  - The patient must currently be on around the clock opioid therapy and have been on round the clock opioid therapy for at least 1 week, as evidenced by paid claims or pharmacy print-outs.
- **Oxycodone IR**
  - The patient must have chronic pain.
  - The patient must currently be on a long-acting narcotic, as evidenced by paid claims or pharmacy print-outs.
  - The prescriber must confirm that they have reviewed the North Dakota PDMP reports for the patient.
  - The patient's current total daily Morphine Equivalent Dose (MED), must be greater than the minimum per tablet strength requested (below), as evidenced by paid claims or pharmacy print-outs.
    - For 15 mg tablet ≥300 MED/day, for 20 mg tablet ≥300 MEDs/day, for 30 mg tablet ≥300 MEDs/day.
- **Oxaydo**
  - The patient must have failed 3 separate trials of generic, immediate-release narcotics, as evidenced by paid claims or pharmacy print-outs.
  - The prescriber must confirm that they have reviewed the North Dakota PDMP reports for the patient.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**Diagnosis for this Request:** □ Chronic Pain □ Cancer Pain □ Other:
Is patient on a long-acting narcotic?	□ YES □ NO
Does the prescriber routinely check the PDMP system?	□ YES □ NO

FAILED THERAPY	**START DATE**	**END DATE**	**DOSE & FREQUENCY**

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

ACE-Inhibitors (ACE-I), Angiotensin II Receptor Blockers (ARB) and Renin Inhibitor PA Form

health information designs

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a prescription for an ACE-I, ARB, Renin Inhibitor, or any combination not listed below must meet the following criteria:

- **ACE-I: Captopril, enalapril, ramipril, lisinopril, trandolapril, quinapril, benazepril, and fosinopril and their hydrochlorothiazide containing combinations do not require a prior authorization. Epaned does not require a PA for patients less than 7 years of age.**
- **Angiotensin II receptor antagonists: Losartan and valsartan do not require a prior authorization.**
- **Renin Inhibitor: Aliskiren and combination products require a prior authorization.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:** **Does patient have symptomatic chronic heart failure (NYHA class II-IV)? □ YES □ NO** **Left ventricular ejection fraction:**		

Failed therapy (list all that apply)	Start Date	End Date
Is the patient unable to ingest solid dosage forms (provide documentation)? □ YES □ NO		
Prescriber (or Staff) / Pharmacy Signature**		Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

ACITRETIN PA FORM

health information designs

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Acitretin must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Patient must be male or female permanently unable to bear children.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:** **Is patient permanently unable to bear children? □ YES □ NO**		
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

ACNE AGENTS
PA FORM

health information designs

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for an acne agent must meet the following criteria:

- **Patients between the ages of 12-35 are eligible for acne treatment.**
- **Requires step therapy. See acne criteria for more information.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name	Dermatologist Involved in therapy:		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this Request:**		
LIST ALL FAILED MEDICATIONS AND REASON:			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

AMPYRA PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

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

- **Patient must be 18 years or older.**
- **Patient must have a specialist (neurologist or physiatrist) involved in therapy.**
- **Patient must have a confirmed diagnosis of multiple sclerosis.**
- **Patient must not have a history of seizures**
- **Patient's CrCl (creatinine clearance) must be greater than 50mL/min**
- **Renewal PA requests must include patient's current T25FW.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name	Specialist involved in therapy (if not treating physician)		
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ AMPYRA	**FDA approved indication for this request:**		
Has patient experienced any acute exacerbations within the last 60 days?	□ YES	□ NO	
Does the patient have a CrCL greater than 50mL/min?	□ YES	□ NO	
Does the patient have a history of seizures?	□ YES	□ NO	
What is the patient's baseline Timed 25-foot Walk (T25FW)?	**If this is a renewal PA request, please include patient's current T25FW:**		
Prescriber (or Staff) / Pharmacy Signature**		Date	

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

ANTIHYPERURICEMICS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for antihyperuricemics must meet the following criteria:

- **Colchicine: Patient must have failed a 30-day trial of Mitigare.**
- **All Others: Patient must have failed a 30-day trial of allopurinol 300 mg or greater.**
- **Zuramic: Patient must have failed a 30-day trial of Uloric and be using Zuramic in combination with allopurinol or Uloric.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number		
Prescriber Name				
Prescriber NPI	Telephone Number	Fax Number		
Address	City	State	Zip Code	
Requested Drug and Dosage:	**Diagnosis for Request:**			
Qualifications for Coverage:				
Medications patient has tried:	Start Date:	End Date:	Dose:	Frequency:
Other medical justification for use (e.g. renal or hepatic impairment):				
Prescriber (or Staff) / Pharmacy Signature**	Date			
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*				

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

ANTIMALARIAL AGENTS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for antimalarial agents must meet the following criteria:

- **For all agents:**
  - Patient must have tried a generic quinine in the last 30 days.
  - Provider must submit an appropriate MedWatch form documenting the trial.
- **For Malarone with NDC 00173067601:**
  - Patient must meet above criteria
  - Patient must be less than 18 years of age.

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for Request:** □ Treatment of malaria		

Qualifications for Coverage:

Medications patient has tried:	Start Date:	End Date:	Dose:	Frequency:

Other medical justification for use (e.g. renal or hepatic impairment):	
Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:		ND MEDICAID PROVIDER NUMBER:
Phone:		FAX:
Drug:		NDC#:

health information designs

Ulcerative Colitis Agents
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires a 30-day trial of all preferred products before non-preferred agent will be authorized.
Note:

- **An FDA approved indication of treatment of flares in patients with moderately active ulcerative colitis is required.**
- **See list of preferred products at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
List all failed medications:	**Start Date:**	**End Date:**	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

CYSTIC FIBROSIS ANTI-INFECTIVES PA FORM

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a new prescription for TOBI, TOBI Podhaler, tobramycin inhalation or Cayston must meet the following criteria:

- Patient must have had a 28 day trial of Bethkis or Kitabis Pak, as evidenced by paid claims or pharmacy print-outs.
- Patient must have an FDA approved indication.
- Patient must be 6 years of age or older (TOBI) and 7 years of age or older (Cayston).
- The patient has not been colonized with Burkholderia cepacia.
- **For Cayston:**
  - Patient must have a FEV1 of less than 25% or greater than 75% predicted
- **For or TOBI, TOBI Podhaler, or tobramycin inhalation**
  - Patient must have a FEV1 of less than 40% or greater than 80% predicted.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
List all failed medications:	**Start Date:**	**End Date:**	
FEV1:_____	Has the patient been colonized with Burkholderia cepacia? □ YES □ NO		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

BOWEL PREP AGENTS PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for a bowel prep agent must meet the following criteria:

- **Patient must first try Golytely.**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number		
Prescriber Name				
Prescriber NPI	Telephone Number	Fax Number		
Address	City	State	Zip Code	
Requested Drug and Dosage:	**Diagnosis for Request:**			
Qualifications for Coverage:				
Medications patient has tried:	Start Date:	End Date:	Dose:	Frequency:
Other medical justification for use (reason Golytely cannot be used):				
Prescriber (or Staff) / Pharmacy Signature**		Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*				

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:		ND MEDICAID PROVIDER NUMBER:
Phone:		FAX:
Drug:		NDC#:

health information designs

CARISOPRODOL PA Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

*Cyclobenzaprine, chlorzoxazone, methocarbamol and orphenadrine do not require a prior authorization.

***Note:**

- **PA will be approved if recipient is currently taking carisoprodol on a chronic basis and provider is weaning patient.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ CARISOPRODOL	**Diagnosis for this request:**		
Qualifications for coverage:			
□ CHRONIC CARISOPRODOL RECIPIENT BEING WEANED (PLEASE INCLUDE WEANING SCHEDULE)	Dose:	Frequency:	
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

CIALIS FOR BENIGN PROSTATIC HYPERPLASIA PA Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for Cialis used to treat benign prostatic hyperplasia (BPH) must meet the following criteria:

- **Patient must have diagnosis of BPH**
- **Patient must try and fail all alpha blockers and 5-alpha reductase inhibitors and combinations, unless contraindicated.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ CIALIS	**Diagnosis for this request:**		
Qualifications for coverage: (please attach any additional notes listed all products failed)			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

COMBINATION PRODUCTS PA FORM

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for a combination product that is more expensive than the individual components must meet the following criteria:

- **Patient must be currently stable on the combination product.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
Qualifications for coverage:			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

COPAXONE 40 mg/mL
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for Copaxone 40m/mL must meet the following criteria:

- **Patient must have a confirmed diagnosis of multiple sclerosis.**
- **Prescriber must be a neurologist.**
- **Patient must have failed a 3 month trial of copaxone 20 mg/mL, Aubagio, Tecfidera, and Gilenya.**
- **The prescriber must provide medical justification indicating why the patient cannot use copaxone 20 mg/mL**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ COPAXONE 40MG	**Diagnosis for this request:**		
List all failed medications:	**Start Date:**	**End Date:**	
Qualifications for coverage:			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Agents Used to Treat COPD
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for non-preferred agents to treat COPD must have a diagnosis of COPD and meet the criteria for the specific agent listed in the North Dakota Medicaid Preferred Drug List (link below):

- http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:** □ COPD □ OTHER:		
List all failed medications:	**Start Date:**	**End Date:**	
Additional Qualifications for Coverage (if applicable, per the specific criteria in the PDL, such as number of exacerbations treated with corticosteroids)			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Inhaled Corticosteroid/Long-Acting Beta-2 Agonists PA FORM

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for non-preferred inhaled corticosteroid/long-acting beta-2 agonist agents must meet the following criteria:

- Patient must have had a 30-day trial with all preferred agents, as evidenced by paid claims or pharmacy print-outs.
- **For COPD diagnosis**, a 30-day trial of one drug from each group below will also be required:
  - Tudorza Pressair, Spiriva, Spiriva Respimat, Incruse Ellipta, Anoro Ellipta, or Stiolto Respimat.
  - Anoro Ellipta, Stiolto Respimat, Foradil, Brovana, Arcapta Neohaler, Striverdi Respimat, Perforomist, or Serevent.
- **For asthma diagnosis**, patient must have been reviewed for step down therapy for all renewal requests.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**Diagnosis for this request:** □ COPD □ ASTHMA □ OTHER:

List all failed medications:	**Start Date:**	**End Date:**

Additional Qualifications for Coverage
For renewal requests & an asthma diagnosis, has the patient must have been reviewed for step down therapy? □ YES □ NO

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

DISPENSE AS WRITTEN PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

North Dakota Medicaid requires that patients receiving a brand name drug, when there is a generic equivalent available, must first try and fail the generic product for one of the following reasons.

- **The generic product(s) are not effective (attach MedWatch form for two different generic manufacturers)**
- **There was an adverse reaction with the generic product(s) (attach MedWatch form for two different generic manufacturers)**
- **DAW not allowed for drugs with an authorized generic available.**
- **Primary insurance requires a ND Medicaid non-preferred brand product.**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name		Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name				
Prescriber NPI		Telephone Number	Fax Number	
Address		City	State	Zip Code
Requested Drug:	**DOSAGE:**	**Diagnosis for this request:**		

QUALIFICATIONS FOR COVERAGE: □ FAILED TWO GENERIC EQUIVALENTS	**Start Date**	**End Date**	**Dose**	**Frequency**

ADVERSE REACTION TO GENERIC EQUIVALENT: □ FDA MEDWATCH FORM ATTACHED FOR EACH GENERIC FAILED

PRIMARY INSURANCE REQUIRES: □ BRAND NAME PRODUCT

Primary insurance carrier: _____

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

DEXPAK/ZEMAPAK
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a new prescription for DexPak or Zema-Pak must meet the following criteria:

- Patient must first try and fail with dexamethasone.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage: □ DEXPAK □ ZEMA-PAK	**Diagnosis for this request:**	
List all failed medications: □ DEXAMETHASONE	**Start Date:**	**End Date:**
Additional Qualifications for Coverage:		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*		
Prescriber (or Staff) / Pharmacy Signature**	Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*		

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Diabetic Testing Supplies
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for non-preferred diabetic testing supplies must provide medical justification for use. Please see a list fo the preferred diabetic testing supplies at http://www.hidesigns.com/assets/files/ndmedicaid/2017/PDSL/North_Dakota_Medicaid_Preferred_Diabetic_Supply_2017-2.pdf

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:** □ OTHER:		
List all failed medications: □ PATIENT HAS AN INSULIN PUMP NOT COMPATIBLE WITH THE PREFERRED TEST STRIPS **What pump does patient use?**			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Diclegis
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a new prescription for Diclegis must meet the following criteria:

- Patient must have diagnosis of nausea and vomiting of pregnancy
- Patient must first try ondansetron, meclizine, and metoclopramide.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage: □ **DICLEGIS**	**Diagnosis for this request:** □ NAUSEA AND VOMITING OF PREGNANCY

List all failed medications:	**Start Date:**	**End Date:**

Additional Qualifications for Coverage:

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

DPP-4 INHIBITORS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for a DPP-4 inhibitor:

- **Diagnosis of Diabetes Type II required**
- **Onglyza: must fail a 3-month trial of metformin and continue taking metformin**
- **For all other agents, patient must fail a 3-month trial of metformin AND continue taking metformin concurrently AND fail a 30-day trial of both a sitagliptin product (Janumet, Janumet XR, or Januvia) and a linagliptin product (Jentadueto or Tradjenta).**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Has patient taken metformin for 3 months? □ YES □ NO** **Will patient continue therapy with metformin and the requested medication? □ YES □ NO** **Please list all medications patient has tried:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

EDECRIN PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Edecrin must meet one of the following criteria:

- **Patient must have a documented sulfa allergy.**
- **Patient must have failed a 30-day trial of bumetanide, furosemide, or torsemide.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		
List all failed medications (drug name, date of trial, reason for failure):			
Additional Qualifications for Coverage:			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

ELAPRASE PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Elaprase must meet the following criteria:

- **Patient must have Hunter Syndrome.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ ELAPRASE	**Diagnosis for this Request:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

ERYTHROPOIESIS-STIMULATING AGENTS
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for erythropoiesis-stimulating agents must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Requires step therapy. Please review criteria for coverage.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: **Diagnosis:**	**Please list all medications patient has tried:**		
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Fulyzaq
Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Fulyzaq must meet the following criteria:
Note:

- **Patient must be 18 years of age or older.**
- **Patient must have non-infectious diarrhea.**
- **Patient must have HIV/AIDS and be taking anti-retroviral therapy.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name:			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
QUALIFICATIONS FOR COVERAGE:			
Requested Drug and Dosage: □ **Fulyzaq**	Diagnosis for this request: Anti-retroviral therapy		
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

GLP-1 RECEPTOR AGONISTS PA FORM

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a new prescription for a non-preferred GLP-1 receptor agonist must meet the following criteria:

- **Patient must have a diagnosis of type 2 diabetes mellitus.**
- **Patient must fail a 3-month trial of metformin and currently be taking metformin.**
- **Patient must have failed a 30-day trial of 2 preferred products (Trulicity and Adlyxin).**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage: □ VICTOZA □ ADLYXIN □ TRULICITY	**Diagnosis for this request:** □ TYPE 2 DIABETES MELLITUS
List all failed medications: □ METFORMIN □ OTHERS:	**Start Date:** / **End Date:**

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

GLUMETZA PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Glumetza must meet the following criteria:

- **Patient must fail a 3-month trial of metformin ER.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		
List all failed medications (drug name, date of trial, reason for failure):			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

GRALISE PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

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

- **Patient must have a diagnosis of postherpetic neuralgia**
- **Patient must first try gabapentin**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ GRALISE	**Diagnosis for this Request:**		
Failed Therapy (dose and frequency): □ GABAPENTIN	**Start Date:** **End Date:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Growth Hormone PA Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving Growth Hormone meet one of the criteria below:

- Growth Hormone Deficiency in children and adults with a history of hypothalamic pituitary disease
- Short stature associated with chronic renal insufficiency before renal transplantation
- Short stature in patients with Turners Syndrome (TS), Prader-Willi Syndrome (PWS), or Noonan, SHOX Syndrome
- Human Immunodeficiency Virus (HIV) associated wasting in adults
- See growth hormone criteria for additional information.
  http://www.hidesigns.com/assets/files/ndmedicaid/2017/Criteria/growth_hormone_criteria_1.pdf

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
REQUESTED DRUG:	**Requested Dosage:** (must be completed)		

Qualifications for coverage:

Diagnosis:	Previous Therapy:	Dose:	Frequency:
Height:	Has patient attained epiphyseal closure?	□ Yes	□ No

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Genitourinary Smooth Muscle Relaxants (GSMR) Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires a 30-day trial of all preferred products before a non-preferred agent will be authorized.
Note:

- **See list of preferred products at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI:	Telephone Number	Fax Number	
Address	City	State	Zip Code
Qualifications for coverage:			
Requested Drug and Dosage:	**Diagnosis for this request:**		
	Failed therapy-List all (Drug and Dose) **Start Date:** **End Date:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

HEREDITARY ANGIOEDEMA PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for an agent used to treat hereditary angioedema must meet the following criteria:

- **Patient must have diagnosis of hereditary angioedema confirmed by a specialist**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name	Specialist Involved in therapy:		
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ BERINERT □ FIRAZYR □ CINRYZE □ KALBITOR	**Diagnosis for this Request:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

HEMANGEOL
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Hemangeol must meet the following criteria:

- **Patient must be between 5 weeks and 1 year of age.**
- **Patient must weigh 2 kg or greater.**
- **Patient must not have contraindications as listed below: asthma or a history of bronchospasm, bradycardia (<80 beats per minute), greater than first-degree heart block, decompensated heart failure, blood pressure <50/30 mmHg, or pheochromocytoma.**
- **Patient must have a diagnosis of proliferating infantile hemangioma requiring systemic therapy.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug: □ HEMANGEOL	Diagnosis: Patient's weight:	Does patient have ANY contraindications to Hemangeol?	
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

HEPATITIS C TREATMENTS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for hepatitis C treatments must meet the following criteria (for further specified criteria, please see the PDL at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf:

- Patient must have an FDA-approved diagnosis and genotype and be of an FDA-approved age for use
- Patient must attest that they will continue treatment without interruption for the duration of therapy and established compliant behavior
- Must be prescribed by or in consultation with a hepatologist, gastroenterologist, or infectious disease specialist
- Prescriber must attach documentation that the patient has been drug and alcohol free for the past 12 months.
- Patient must be tested for hepatitis B and must either be treated or closely monitored if the test is positive.
- HCV RNA level must be taken on week 4 and sent with a renewal request for any duration of treatment 12 weeks or longer.
- Females using ribavirin must have a negative pregnancy test in the last 30 days and receive monthly pregnancy tests during treatment
- Patient must not have life expectancy of less than 12 months due to non-liver related comorbid conditions.
- For non-preferred agents: Patient must have failed a trial of all preferred treatment options indicated for the patient's genotype.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dose:	**Duration requested:**	**Patient is drug and alcohol free for past 12 months:** □ YES □ NO
Diagnosis:	**Genotype:**	**Patient's Child-Pugh class:** □ A □ B □ C □ N/A

Please list any previous treatments the patient has failed for chronic HCV: □ N/A	Regimen:	Dates of treatment:	Response:

Will the requested medication be given with ribavirin to a patient of child bearing potential?	□ YES □ NO
If yes, has the patient had a negative pregnancy test in the last 30 days?	□ YES □ NO □ N/A
Will the receive pregnancy tests monthly during treatment?	□ YES □ NO □ N/A
Is the patient taking the requested medication in combination with another HCV treatment? □ YES □ NO	Other Agent(s) used:
Does the patient have Hepatitis B?	□ YES □ NO
If the patient has Hepatitis B, has it been treated or will it be closely monitored during treatment?	□ YES □ NO
Is the patient post-liver transplant?	□ YES □ NO
Does the patient's life expectancy greater than one year?	□ YES □ NO
Does patient attended scheduled visits with no more than 1 no-show and fill maintenance medications on time?	□ YES □ NO
Does patient have any contraindications to therapy with the requested agent?	□ YES □ NO

Please confirm that all of the following is attached to the request, along with any other documentation required, as stated in the PDL:

□ Baseline HCV RNA
□ ≥ 2 drug and alcohol tests dated at least 3 months apart
□ Patient attestation form
□ HCV RNA 4 weeks after starting therapy (for renewal)
□ Chart notes addressing patient's alcohol and drug free status over the past year

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Hepatitis C Patient Consent Form

I, _____, have been counseled by my healthcare provider on the following:

- ☐ I agree to complete the entire course of treatment and have laboratory tests before starting, during, and after completing treatment as ordered by my healthcare provider.
- ☐ I understand that for the medication to work, it is important that I take my medication each day for the entire course of treatment.
- ☐ I understand the importance to not drink alcohol or use illicit drugs during and after my treatment for Hepatitis C.
- ☐ I understand how to avoid being re-infected with Hepatitis C during and after my treatment.
- ☐ (Females) I understand that these drugs are harmful to babies. I will use two methods to avoid getting pregnant. I understand that this medication may cause serious birth defects to an unborn child for up to 6 months after I have completed my treatment.
- ☐ (Males) I understand that while I am taking the medication, I must avoid getting my partner pregnant. If my partner becomes pregnant, the baby may have serious birth defects. My partner and I will prevent pregnancy using two forms of birth control for up to 6 months after my treatment is complete. If I have a committed partner, I have discussed these risks with her.

Patient Signature _____ Date __/__/___

Pharmacy or Prescriber Representative:

Signature _____ Date __/__/____

By signature, the pharmacy or prescriber representative confirms the contract has been reviewed with the patient.

health information designs

Horizant Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Horizant must follow the following guidelines:

- ***Patient must have a diagnosis of Restless Leg Syndrome.***
- ***Patient must have had a trial of gabapentin, pramipexole, or ropinirole.***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Horizant**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED THERAPY START DATE: DOSE: END DATE: FREQUENCY:			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Medications used to treat IBS/OIC
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for medications used to treat IBS/OIC must meet the following criteria:

- *Patient must have diagnosis of chronic constipation, IBS with constipation, or opioid-induced constipation.*
- *Requires step therapy. See IBS/OIC criteria for more details.*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

QUALIFICATIONS FOR COVERAGE:

Requested Drug and Dosage:	Diagnosis for this request: Is the patient unable to tolerate oral medications?
Failed therapy:	Start Date: End Date:

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

IMMUNE GLOBULINS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for an immune globulin must meet the following criteria:

- **If patient's BMI > 30, adjusted body weight must be provided along with the calculated dose.**
- **For Gammagard S/D – patient must be intolerant to IgA.**
- **For Hizentra, Cuvitru, or Hyqvia – patient must be unable to tolerate IV administration and fail a trial of two of the following: Gamunex-C, Gammaked, or Gammagard.**
- **For all other agents, patient must try and fail two of the following: Gamunex-C, Privigen, or Gammagard.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: **Indication for this request:**	**Is patient BMI over 30? □ YES □ NO** **If yes, provide adjusted body weight and calculated dose:** **Is patient intolerant to IgA (i.e., treatment of an autoimmune process in a patient with undetectable levels of IgA)? □YES □NO** **Is patient unable to tolerate IV administration? □ YES □ NO** **Please list all medications patient has tried and failed:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

INJECTABLE ANTICOAGULANTS PA FORM

health information designs

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for injectable anticoagulants must meet the following criteria:

- **Patient must have an FDA approved indication.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:** **Does the patient have an indication that cannot be treated with Lovenox?** **Does the patient need Extended Treatment for Symptomatic Venous Thromboembolism in Patients with Cancer? □ YES □ NO**		
History of preferred agents (drug name, dates of trial, reason for failure):			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Insulins
Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for a non-preferred insulin must first try a 30-day trial of one preferred agent in the past year.

- **For all non-preferred long-acting insulins:**
  - Patient must have failed patient failed a 3 month trial of both Lantus and Levemir with good compliance.
    - Must have required at least 100 units/day for Tresiba U-200 and Toujeo.
- **For pens/syringes when vials are available:**
  - Patient must have failed at least a 30-day trial using the vial product OR have valid medical justification explaining why the patient cannot use the vial.
- **For Fiasp:**
  - Patient must have failed a 30-day trial with at least 3 preferred agents in the past year.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
QUALIFICATIONS FOR COVERAGE:			
Requested Drug and Dosage:		Diagnosis for this request:	
Failed Therapy:		Start Date: End Date:	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

INTERFERONS – MULTIPLE SCLEROSIS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for interferon must meet the following criteria:

- **Patient must have a confirmed diagnosis of multiple sclerosis.**
- **A three month trial of a preferred agent will be required before a non-preferred agent will be authorized.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		
Prior therapy: **Start date:**	**End date:**		
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

INTERLEUKIN-5 ANTAGONIST PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for an interleukin-5 antagonist must meet the following criteria:

- **Patient must have a diagnosis of asthma.**
- **Patient must have blood eosinophils of ≥ 150 cells/microliter within the last 6 weeks.**
- **Patient must have had 3 fills of a high dose steroid and a controller medication in the past 120 days.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:** **Blood eosinophil count:** **Date of eosinophil count:**		
List all failed medications (drug name, date of trial, reason for failure): **Does patient have a history of 2 or more exacerbations in the previous year? □ YES □ NO** **Has patient had a decreased frequency of exacerbations (worsening of asthma requiring an increase in ICS dose or treatment with systemic corticosteroids)? □ YES □ NO** **Has patient's predicted FEV1 increased from pretreatment baseline? □ YES □ NO** **Has patient had 3 fills of high dose steroids in the past 120 days? □ YES □ NO** **Has patient had 3 fills of a controller medication in the last 120 days? □ YES □ NO**			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

AGENTS USED TO TREAT IDIOPATHIC PULMONARY FIBROSIS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for agents used to treat idiopathic pulmonary fibrosis must meet the following criteria:

- **Patient must be 18 years of age or older.**
- **Patient must have documented diagnosis of idiopathic pulmonary fibrosis.**
- **Patient must have a specialist involved in therapy.**
- **Patient must have forced vital capacity (FVC) ≥ 50% of predicted within prior 60 days.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist Involved in Therapy		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug: □ OFEV □ ESBRIET	Diagnosis: FVC:	Is patient pregnant? □ YES □ NO Is patient of child-bearing potential? □ YES □ NO Have LFTs been measured? □ YES □ NO Does patient have moderate to severe liver impairment? □ YES □ NO Does patient currently smoke? □ YES □ NO	
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

KALYDECO PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Kalydeco must meet the following criteria:

- **Patient must be 2 years of age and older and have one of the following mutations in the cystic fibrosis conductance regulator (CFTR) gene: G551D, G1244E, G1349D, G178R, G551S, R117H, S1251N, S1255P, S549N, or S549R.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ KALYDECO	**Diagnosis for this Request:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

KAPVAY PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Kapvay must meet the following criteria:

- **Patient must first try immediate release clonidine**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ KAPVAY	**Diagnosis for this Request:**		
Failed Therapy (dose and frequency): □	**Start Date:** **End Date:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

KETEK PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Ketek must meet the following criteria:

- ND Medicaid will cover Ketek with a diagnosis of community-acquired pneumonia (of mild to moderate severity) due to Streptococcus pneumoniae for patients 18 years and older.
- ND Medicaid will cover Ketek for patients with an allergy to fluoroquinolones or tetracyclines.

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

REQUESTED DRUG: □ **KETEK**	**Requested Dosage:** (must be completed)

Qualifications for coverage:

□ Community acquired pneumonia (of mild to moderate severity) due to Streptococcus pneumoniae, (including multi-drug resistant isolates, Haemophilus influenzae, Moraxella catarrhalis, Chlamydophila pneumoniae, or Mycoplasma pneumoniae) for patients 18 years and older.

Does the patient have myasthenia gravis?

Does the patient have any other antibiotic use in the last 3 months?

□ Please list fluoroquinolone or tetracycline that patient is allergic to:

_____

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

KITS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for a kit must:

- **Use the covered product included in the kit as an individual product**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Is the covered medication included in the kit available commercially as an individual product?**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

KUVAN PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Kuvan must meet the following criteria:

- **Patient must have hyperphenalaninemia.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name		**Recipient Date of Birth**	Recipient Medicaid ID Number
Prescriber Name			
Prescriber NPI		Telephone Number	Fax Number
Address		City	State / Zip Code
Requested Drug and Dosage: □ KUVAN	**PHE level:**	**Diagnosis for this Request:**	**Patient's weight:**

Has the patient been known to have two null mutations in TRANS?	□ **YES**	□ **NO**
Are baseline PHE levels attached?	□ **YES**	□ **NO**
Is patient of child-bearing potential?	□ **YES**	□ **NO**
Is this a renewal request?	□ **YES**	□ **NO**

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

LEMTRADA PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Lemtrada must meet the following criteria:

- **Patient must have a confirmed diagnosis of multiple sclerosis.**
- **Requires step therapy. See Lemtrada criteria for more information.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ LEMTRADA	**FDA approved indication for this request:**		

• **Has patient experienced a reduction in relapse rate? (renewal requests)**	□ YES	□ NO
• **Is the patient experiencing early aggressive disease? (>=2 relapses in the year and >= 1 Cadolinium (Cd)+ lesion)?**	□ YES	□ NO
• **Does the patient have VZV antibodies/vaccination or history of varicella?**	□ YES	□ NO
• **Does the patient have appropriate SCr levels?**	□ YES	□ NO
• **Does the patient have appropriate urinalysis with urine cell counts?**	□ YES	□ NO
• **Has the patient had thyroid function tests?**	□ YES	□ NO
• **Has the patient had a TB test?**	□ YES	□ NO

List all failed medications:	**Start Date:**	**End Date:**

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

LICE MEDICATIONS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for lice medications must meet one of the following criteria:

- **Patient must have failed a 28-day trial (2 applications) of each of the preferred agents.**
- **Non-preferred agents will require an FDA approved indication.**
- **See list of preferred products at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf**
-

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		
List all failed medications (drug name, date of trial, reason for failure):			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

LORZONE PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Lorzone must meet the following criteria:

- **Patient must first try chlorzoxazone**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ LORZONE	**Diagnosis for this Request:**		
Failed Therapy (dose and frequency): □ CHLORZOXAZONE	**Start Date:** **End Date:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

LUZU
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Luzu must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Patient must be 18 years of age or older.**
- **Patient must have documented history of failure of two topical antifungal agents (clotrimazole, econazole) and two oral antifungal agents (terbinafine, fluconazole, itraconazole).**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ LUZU	**Diagnosis for this Request:**		
List all failed medications:	**Start Date:**	**End Date:**	
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Marinol
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Marinol must meet the following criteria:

- Patient must have diagnosis of anorexia associated with weight loss in patients with AIDS; or
- Diagnosis of nausea and vomiting associated with cancer chemotherapy

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

QUALIFICATIONS FOR COVERAGE:

Requested Drug and Dosage: □ **Marinol**	□ Diagnosis of anorexia associated with weight loss in patients with AIDS □ Diagnosis of nausea and vomiting associated with cancer chemotherapy Diagnosis for this request:

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

MEDICATIONS > $3,000
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for medications that cost >$3,000 must meet the following criteria:

- **Patient must have an FDA approved indication for the medication requested.**
- **May be subject to additional criteria. See PA criteria for complete details.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:

□ ARCALYST	□ EMFLAZA	□ PHENOXYBENZAMINE
□ AUSTEDO	□ ESBRIET	□ PROCYSBI
□ BUPHENYL	□ JUXTAPID	□ PROMACTA
□ CARBAGLU	□ KEVEYIS	□ QUTENZA
□ CHENODAL	□ KORLYM	□ RAVICTI
□ CHOLBAM	□ KYNAMRO	□ SAMSCA
□ CUPRIMINE	□ MIACALCIN	□ SOMAVERT
□ CERDELGA	□ NATPARA	□ STRENSIQ
□ DARAPRIM	□ OCALIVA	□ TETRABENAZINE
□ DUPIXENT	□ ORFADIN	□ ZAVESCA

FDA approved indication for this request:

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

METOZOLV ODT PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

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

- **Patient must try metoclopramide.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage: □ METOZOLV		**Diagnosis for this request:**	
□ **FAILED METOCLOPRAMIDE THERAPY**	**START DATE**	**END DATE**	**DOSE**
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

MIFEPREX
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Mifeprex must meet the following criteria:

- **Patient must have an FDA approved indication for the medication requested.**
- **Prescriber must provide signed written statement. See criteria for more information.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		

- **Is the patient terminating a pregnancy before 49 days of pregnancy? □ YES □ NO**
- **Is the pregnancy resulting from an act of rape or incest? □ YES □ NO If yes, fill out section 1. If no, fill out section 2:**

Section 1:

- **Has the appropriate law enforcement agency been notified, or agency authorized to receive child abuse and neglect reports? □ YES □ NO**
  If yes, has the provider provided a signed written statement indicating that the rape or act of incest has been reported and to whom the report was made?
  If no, has the provider provided signed written verification that in the provider's professional judgment, the woman's pregnancy resulted from rape or incest? □ YES □ NO
  Has the provider provided a written statement signed by the recipient that her current pregnancy resulted from an act of rape or incest? □ YES □ NO

Section 2:

- **Does the woman suffer from a physical disorder that would place the woman in danger of death unless abortion is performed? □ YES □ NO**
- **Has the treating provider provided a signed written statement that, in the provider's professional judgment, the life of a woman would be endangered if the fetus were carried to term? □ YES □ NO**
- **Does the statement contain the reasons why the physician believes the life of the woman would be in danger if the fetus were carried to term? □ YES □ NO**

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

MOXATAG PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Moxatag must submit documentation of allergies or show a history of intolerable side effects to the inactive ingredients in regular-release amoxicillin.

- Regular-release amoxicillin does not require a prior authorization.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code

REQUESTED DRUG : □ MOXATAG	**Dosage**
Qualifications for coverage:	
□ Allergic/intolerable side effects to inactive ingredients of regular-release amoxicillin. Name of inactive ingredient: _____	Diagnosis for this request:
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*	
Prescriber (or Staff) / Pharmacy Signature**	Date
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*	

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

NALTREXONE – ORAL PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for naltrexone must meet the following criteria:

- **FDA approved indication is alcohol dependence or opioid use disorder.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Indication for this request:**		
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Proton Pump Inhibitor PA Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

health information designs

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving proton pump inhibitors must meet the following criteria:
__Note:__

- **Omeprazole, lansoprazole, pantoprazole, Dexilant, Protonix packet, and Nexium packet do not require prior authorization.**
- **Requires step therapy. See PPI criteria for more information. www.hidesigns.com/ndmedicaid**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
REQUESTED DRUG: □ Rabeprazole □ Prevacid Solutab □ Zegerid Packet □ Protonix Packet □ Nexium □ Dexilant □ Aciphex Sprinkle	**Requested Dosage:** (must be completed) **Diagnosis for this request:**		
List all failed medications:	**Start Date:**	**End Date:**	
□ Pregnancy – Due Date			
□ Inability to take or tolerate oral tablets (must check a box) □ NG tube □ Other tube _____ □ Requires soft food or liquid administration □ Other (provide description)			
□ Adverse reaction (attach FDA Medwatch form) to omeprazole/pantoprazole.			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Nuedexta
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a new prescription for Nuedexta must have a diagnosis of amyotrophic lateral sclerosis (ALS) or multiple sclerosis (MS) and exhibit signs of pseudobulbar affect.

- Nuedexta is indicated for the treatment of pseudobulbar affect (PBA).
- Nuedexta has not been shown to be safe or effective in other types of emotional lability that can commonly occur, for example, in Alzheimer's disease and other dementias.
- Nuedexta is contraindicated in patients with a prolonged QT interval, heart failure, or complete atrioventricular (AV) block.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**Diagnosis for this request (must check at least 2):**
□ NUEDEXTA	□ **PBA: Include baseline PBA episode count**_____ **If request is a renewal, include current PBA episode count**_____ □ **ALS** □ **MS**

List all failed medications:	**Start Date:**	**End Date:**

Is the Center for Neurological Studies liability baseline attached? (CNS-LS)	□ YES □ NO
If request is a renewal, is the CNS-LS current attached?	□ YES □ NO
Does the patient have a prolonged QT interval, heart failure, or complete atrioventricular (AV) block?	□ YES □ NO
What is the neurologic condition causing PBA? _____	
Is TBI due to penetrating head injury?	□ YES □ NO
Has the neurologic condition been stable for at least 3 months?	□ YES □ NO

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Nitroglycerin Lingual Spray
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Nitrolingual Spray must meet the following criteria:

- *Patient must first try sublingual tablets*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name:			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code

QUALIFICATIONS FOR COVERAGE:

Requested Drug and Dosage: □ **Nitroglycerin Lingual Spray**	Diagnosis for this request:	
List all failed medications:	**Start Date:**	**End Date:**
Failed Therapy:	Start Date: End Date:	
Prescriber (or Staff) / Pharmacy Signature**	Date	

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

NK_1 RECEPTOR ANTAGONISTS PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for NK_1 receptor antagonists must meet the following criteria:

- **Patient must have a diagnosis of nausea and/or vomiting.**
- **Patient must be receiving a moderately or highly emetogenic chemotherapy.**
- **Prescriber must be an oncologist.**
- **Patient must have failed a cycle using aprepitant or fosaprepitant in combination with palonosetron and a glucocorticoid.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:** **Chemotherapy being used:** **How many cycles of chemotherapy will need NK_1 receptor antagonist treatment?** **Date of final chemotherapy treatment:**		
List all failed medications (drug name, date of trial, reason for failure):			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

NORTHERA
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Northera must meet the following criteria:

- **Patient must have an FDA approved indication.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ NORTHERA	**Diagnosis for this Request:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

NOXAFIL
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Noxafil must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Patient must have documented history of failure of two agents (itraconazole, fluconazole) to receive Noxafil suspension for oropharyngeal candidiasis.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage: □ NOXAFIL TABLET □ NOXAFIL SUSPENSION	**Diagnosis for this Request:**
Failed Therapy for Oropharyngeal Candidiasis (suspension only): **1.** **2.**	**Start Date:** **End Date:** **1.** **2.**
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*	
Prescriber (or Staff) / Pharmacy Signature**	Date
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*	

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

NSAID/COX-II PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients using NSAIDs or COX-II drugs must use a generic NSAID first line.
***Note: The PA will be approved if one of the following criteria is met:**

- Failed two trials of prescribed oral NSAIDs to receive brand name oral NSAIDs
- Failed trial of Voltaren gel to receive brand name topical NSAIDs for inflammation
- Recipient is on warfarin or corticosteroid therapy
- Recipient has history of gastric or duodenal ulcer or has comorbidities of GI bleed, perforation or obstruction
- Recipient has history of endoscopically documented NSAID induced gastritis with GI bleed
- Solaraze will be covered for patients with a diagnosis of actinic keratoses

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ CELECOXIB □ OTHER:_____	**Diagnosis for this request:** □ Warfarin/Corticosteroid therapy □ GI bleed, perforation or obstruction □ Gastric or duodenal ulcer □ Endoscopically documented NSAID gastritis with GI Bleed □ Actinic keratoses **(Solaraze)**		
List all failed medications:	**Start Date:**	**End Date:**	

Qualifications for coverage:

Does patient have arthritis requiring long-term high dosage of NSAIDS?	□ YES □NO
Is patient at high risk for mucosal injury?	□ YES □NO
Is the patient taking aspirin at any dose?	□ YES □NO
Is patient at risk of cardiovascular disease?	□ YES □NO
Will prescriber continue to weigh GI benefits against CV risks and discontinue COX-II as soon as possible?	□ YES □NO

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

NUVESSA PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Nuvessa must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Requires step therapy.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		
	Is the patient pregnant? □ **YES** □ **NO**		
History of preferred agents (drug name, dates of trial, reason for failure):			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Orally Disintegrating Tablets (ODT) Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed an orally disintegrating tablet must first try a more cost-effective dosage form.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Unable to Swallow □ Medication Failed _____	Start Date: End Date:	Dose: Frequency:	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Onmel
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Onmel must meet the following criteria:

- *Patient must receive two medically necessary courses of therapy with itraconazole (Sporanox) and terbinafine (Lamisil)*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name:			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
QUALIFICATIONS FOR COVERAGE:			
Requested Drug and Dosage: □ **Onmel**		Diagnosis for this request:	
PRESCRIBER (OR STAFF) / PHARMACY SIGNATURE**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

ONYCHOMYCOSIS AGENTS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for onychomycosis treatment must meet the following criteria:

- **Patient must have a confirmed diagnosis of onychomycosis by one of the following: KOH prep test, fungal culture, or nail biopsy.**
- **Patient must have a history of failure to itraconazole and/or terbinafine.**

Part I: TO BE COMPLETED BY PHYSICIAN

<table>
<tr><td>Recipient Name</td><td>Recipient Date of Birth</td><td colspan="2">Recipient Medicaid ID Number</td></tr>
<tr><td colspan="4">Physician Name</td></tr>
<tr><td>Physician Medicaid Provider Number</td><td>Telephone Number</td><td colspan="2">Fax Number</td></tr>
<tr><td>Address</td><td>City</td><td>State</td><td>Zip Code</td></tr>
<tr><td rowspan="2">Requested Drug:

□ JUBLIA

□ KERYDIN

□ SPORANOX (ITRACONAZOLE)

□ ONMEL (ITRACONAZOLE)</td><td>Diagnosis:

Confirmed diagnosis by (provide documentation):
□ KOH PREP TEST
□ FUNGAL CULTURE
□ NAIL BIOPSY</td><td colspan="2" rowspan="2"><u>First Trial:</u>

Start Date:

End Date:

<u>Second Trial:</u>

Start Date:

End Date:</td></tr>
<tr><td>Is treatment for fingernails only?
□ YES □ NO</td></tr>
<tr><td colspan="4">□ I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.</td></tr>
<tr><td colspan="3">Prescriber (or Staff) / Pharmacy Signature**</td><td>Date</td></tr>
<tr><td colspan="4">**: By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.</td></tr>
</table>

Part II: TO BE COMPLETED BY PHARMACY

<table>
<tr><td colspan="3">PHARMACY NAME:</td><td>ND MEDICAID PROVIDER NUMBER:</td></tr>
<tr><td>TELEPHONE NUMBER</td><td>FAX NUMBER</td><td>DRUG</td><td>NDC #</td></tr>
</table>

health information designs

OPHTHALMIC ANTI-INFECTIVES / ANTI-INFLAMMATORIES PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed a non-preferred ophthalmic corticosteroids/anti-infectives must meet the following criteria:

- **Requires step therapy. Please see criteria for coverage in the Preferred Drug List at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
List all failed medications:	**Start Date:**	**End Date:**	
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Ophthalmic Antihistamines
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for ophthalmic antihistamines must meet the following criteria:

- ***Requires step therapy. Please see criteria for coverage in the Preferred Drug List at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
List all failed medications:	**Start Date:**	**End Date:**	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

OPIOID DEPENDENCE PA FORM

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for buprenorphine and buprenorphine/naloxone combinations must meet the following criteria:

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

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name	**(SAMHSA ID-X DEA Number)**		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ BUPRENORPHINE/NALOXONE □ZUBSOLV □ SUBUTEX □ SUBOXONE FILM □ BUNAVAIL	**FDA Approved Indication for this request:**		
□ Patient is not taking other opioids, tramadol, or carisoprodol concurrently with requested medication.			
Has a contract between the prescriber and patient been signed? □ YES □ NO Does the prescriber perform routine drug screens? □ YES □ NO Does the prescriber routinely check the PDMP system? □ YES □ NO			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

ORAL ALLERGEN EXTRACTS PA FORM

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for oral allergen extracts must meet the following criteria:

- **Patient must have the FDA approved indication for the drug requested.**
- **Diagnosis confirmed by positive skin test or *in vitro* testing for pollen-specific IgE antibodies.**
- **History of failure, contraindication, or intolerance to two of the following: oral antihistamine, intranasal antihistamine, intranasal corticosteroid, or leukotriene inhibitors.**
- **History of failure or intolerance to subcutaneous allergen immunotherapy (allergy shots).**
- **Patient must not have severe, unstable, or uncontrolled asthma.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug:	**Diagnosis for this Request:**	**History of Failure:**
□ GRASTEK	□ GRASS POLLEN-INDUCED ALLERGIC RHINITIS	**1.**
□ ORALAIR	□ RAGWEED POLLEN-INDUCED ALLERGIC RHINITIS	**2.**
□ RAGWITEK	Is the diagnosis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies? □ YES □ NO Doe the patient have severe, unstable, or uncontrolled asthma? □ YES □ NO	**3.**

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Oravig Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires patients receiving a prescription for Oravig to try fluconazole, clotrimazole, nystatin or itraconazole.
Note:

- ***Fluconazole, clotrimazole, nystatin, or itraconazole do not require PA***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Oravig**	**Diagnosis for this request:**		
Qualifications for coverage:			
List all failed medications:	**Start Date:**	**End Date:**	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

OTEZLA
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Otezla must meet the following criteria:

- **Patient must be 18 years of age or older.**
- **Patient must have active psoriatic arthritis or moderate to severe plaque psoriasis.**
- **Patient must have a specialist involved in therapy.**
- **Patient must not use Otezla in combination with other biologic therapies.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name		Recipient Date of Birth		Recipient Medicaid ID Number
Physician Name		Specialist Involved in Therapy		
Physician Medicaid Provider Number		Telephone Number		Fax Number
Address		City	State	Zip Code
Requested Drug: □ OTEZLA	Diagnosis for this Request:	History of Failure:	Is Otezla being used in combination with other biologic therapies?	
Prescriber (or Staff) / Pharmacy Signature**			Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*				

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Otic Anti-Infectives
Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for an otic anti-infective must first try a 7-day trial of a preferred agent in the past 3 months.

- **Requires a trial and failure of a preferred agent**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
QUALIFICATIONS FOR COVERAGE:			
Requested Drug and Dosage:		Diagnosis for this request:	
Failed Therapy:		Start Date: End Date:	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

OUT OF STATE PHARMACY FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

Part I

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number

Requested Drug and Dosage:

Qualifications for coverage:

Start Date	End Date	Dose	Frequency

Reason for out of state pharmacy request:

Recipient is residing out of state? □ YES □ NO
If yes, please provide recipient residence, city, state, zip code:

Requested drug is only available at out of state pharmacies? □ YES □ NO

Third party requires out of state pharmacy for coverage? □ YES □ NO
If yes, contact State Provider Relations at 1-800-755-2604.

Part II

PHARMACY NAME (REQUIRED)			ND MEDICAID PROVIDER NUMBER (REQUIRED)
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC # (REQUIRED)

Pharmacy Signature:	Date:

health information designs

PULMONARY ARTERIAL HYPERTENSION AGENTS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for an agent used to treat pulmonary arterial hypertension (PAH) must meet the following criteria:

- **Patient must have diagnosis of PAH confirmed by a specialist**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name	Specialist Involved in therapy:		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this Request:**		
	Is the patient pregnant? □ Yes □ No Will patient take monthly pregnancy tests during therapy? □ Yes □ No Have LFT's been measured for baseline? □ Yes □ No Will LFT's be measured monthly? □ Yes □ No Does the patient have Class 2 PAH? □ Yes □ No Is the patient taking nitrates of any form? □ Yes □ No If the request is for Tyvaso, is the patient also taking sildenafil, Adcirca, Letairis, bosentan, or Opsumit? □ Yes □ No If the request is for Ventavis 20mcg/mL is the patient repeatedly experiencing incomplete dosing due to extended treatment time? □ Yes □ No		
List all failed medications:	**Start Date:**	**End Date:**	
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

PCSK9 INHIBITORS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for PCSK9 inhibitors must meet the following criteria:

- **Patient must have a confirmed diagnosis of heterozygous familial hypercholesterolemia (Praluent only), clinical atherosclerotic cardiovascular disease, or homozygous familial hypercholesterolemia (Repatha only).**
- **Requires step therapy.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		
	LDL level:		
List all failed medications:	**Start Date:**	**End Date:**	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Prior Authorization Vendor for ND Medicaid

PHOSPHATE BINDERS PA FORM

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

ND Medicaid requires that patients receiving a new prescription for phosphate binders must meet the following criteria:

- **Patient must have an FDA approved indication.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	Diagnosis:	Does patient have chronic kidney disease? □YES □NO If so, what stage? _____
	Lab: Phosphate Level:_____ _____	List failed medications and tell reason:

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

PLATELET AGGREGATION INHIBITORS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for platelet aggregation inhibitors must meet the following criteria:

- **Patient must first try at least two of the following: Brilinta, Effient, clopidogrel, ticlopidine, dipyridamole, dipyridamole/aspirin, or aspirin.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Please list all medications patient has tried:**		
Please list reason that immediate release aspirin is not an option: **If request is for Zontivity, will patient take with aspirin and/or clopidogrel?** **Does the patient have a history of stroke, transient ischemic attack, or intracranial hemorrhage?**			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Promacta Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed Promacta must follow these guidelines:

- ***Patient must have a confirmed diagnosis of chronic immune (idiopathic) thrombocytopenia, Severe Aplastic Anemia, or Hepatitis C.***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Promacta**	**Diagnosis for this request:**		
□ **Failed corticosteroid or immunoglobulin therapy** **DRUG:** **Start Date:** **End Date:** **Dose:** **Frequency:** **Has patient had a splenectomy?** □ YES □ NO **Does patient have Hepatitis C infection currently being treated or to be treated with interferon-based therapy?** □ YES □ NO	**Is patient at increased risk of bleeding due to degree of thrombocytopenia and clinical condition?** □ YES □ NO **Does degree of thrombocytopenia prevent initiation of or ability to maintain interferon-based therapy?** □ YES □ NO **Does patient have a diagnosis of Severe Aplastic Anemia?** □ YES □ NO **Has patient had an insufficient response to immunosuppressive therapy?** □ YES □ NO		
Prescriber (or Staff) / Pharmacy Signature**		Date	

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Provigil/Nuvigil
Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Provigil or Nuvigil must suffer from excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome, narcolepsy, or shift work disorder.

- **Provigil must be used before Nuvigil will be approved.**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Nuvigil** □ **Provigil**	**Diagnosis for this request:** □ EXCESSIVE SLEEPINESS ASSOCIATED WITH OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME □ NARCOLEPSY □ SHIFT WORK SLEEP DISORDER		
□ FAILED PROVIGIL (Nuvigil Requests)	START DATE: END DATE:	DOSE: FREQUENCY:	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Pulmozyme
Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Pulmozyme must meet the following criteria:

- **Patient must have a confirmed diagnosis of cystic fibrosis**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name:			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
QUALIFICATIONS FOR COVERAGE:			
Requested Drug and Dosage: □ **Pulmozyme**		Diagnosis for this request:	
PRESCRIBER (OR STAFF) / PHARMACY SIGNATURE**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

RASUVO AND OTREXUP PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Rasuvo or Otrexup must meet the following criteria:

- **Patient must have an FDA approved indication for the medication requested.**
- **Patient must have tried and failed methotrexate.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		
List all failed medications:	**Start Date:**	**End Date:**	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Rayos
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

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

- **Patient must first try generic prednisone.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name:			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
QUALIFICATIONS FOR COVERAGE:			
Requested Drug and Dosage: □ **Rayos**	Diagnosis for this request:		
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

RIBAPAK PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for RibaPak must meet the following criteria:

- **Patient must first try Ribavirin or Ribasphere.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ RIBAPAK	**FDA Approved Indication for this request:**		

□ **Failed therapy with Ribavirin or Ribasphere** Attach MedWatch form	**Start Date**	**End Date**	**Dose**

WHAT IS THE HCV GENOTYPE? (I-IV)

***TREATMENT WILL BE COVERED FOR 24 TO 48 WEEKS BASED UPON GENOTYPE AND DIAGNOSIS.**

□ Treatment regimen for Hepatitis C will include pegylated or non-pegylated interferon in combination with oral ribavirin.

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

ROSACEA PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

Note: ND Medicaid will not pay for Solodyn, Soolantra, or Oracea without documented failure of a first line tetracycline agent.

- First line agents include minocycline and tetracycline.
- Requires step therapy. See Oracea criteria for more information.

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
REQUESTED DRUG: □ **ORACEA** □ **SOLODYN** □ **SOOLANTRA**	**Requested Dosage:** (must be completed)		
□ Patient has failed a 90 day trial of which first line agent _____ □ Moderate to severe acne □ Severe acne			
List all failed medications:	**Start Date:**	**End Date:**	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Sancuso PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Sancuso must be unable to take oral medications.
Note:

- ***Dolasetron, oral granisetron, and ondansetron do not require PA.***
- ***Patients must be unable to take oral medications or***
- ***Patients must fail therapy on ondansetron or oral granisetron before a PA may be granted.***

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Sancuso**	**Diagnosis for this request:**		
	Does the patient have breast, head/neck, gastrointestinal, or gynecological cancer? **Is the patient taking chemotherapy? If so, please list date of last chemotherapy treatment:**		
List all failed medications:	**Start Date:**	**End Date:**	
□ PATIENT UNABLE TO TAKE ORAL MEDICATIONS			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Sedative/Hypnotic PA Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for a name brand Sedative/Hypnotic must use Ambien® (zolpidem) as first line therapy.

*__Note:__

- **Requires step therapy. See Sedative/Hypnotic PA criteria for more information.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
Qualifications for coverage:			
List all failed medications:	**Start Date:**	**End Date:**	

Have other conditions causing sleep issues been ruled out? □ YES □ NO
Does the patient require dose tapering? □ YES □ NO
Is the patient's insomnia characterized by difficulty with sleep maintenance? □ YES □ NO
Is the patient's insomnia characterized by difficulty with sleep initiation? □ YES □ NO
Is the patient's insomnia characterized by difficulty with middle of the night awakening with more than 4 hours left to sleep? □ YES □ NO

□ I *confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

SGLT2 Inhibitors
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for SGLT2 inhibitors must meet the following criteria:

- **Patient must have diagnosis of Type II Diabetes.**
- **Requires step therapy. Please see criteria for coverage in the Preferred Drug List at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:		Diagnosis for this request:	
Failed therapy:	Start Date:	End Date:	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Spinraza PA Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a prescription for Spinraza must meet the following criteria:

- **For a diagnosis of Spinal Muscular Atrophy (SMA) Type 1, 2 or 3:**
  - **Patient must be less than 2 years of age**
  - **Patient must not have respiratory insufficiency**
  - **i.e. Need for invasive or noninvasive ventiliation for more than 6 hours per 24 hour period.**
  - **Patient must not require gastric feeding tubes for the majority of feeds**
  - **Patient must not have severe contractures or severe scoliosis**
  - **Patient must not have wasting or cachexia**
- **For a diagnosis of Spinal Muscular Atrophy (SMA) Type 3:**
  - **The patient must be experiencing issues with ambulating**
    - **e.g. falls, trouble climbing stairs, unable to walk independently**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dose:			
Diagnosis for this request: □ **SMA Type 1** □ **SMA Type 2** □ **SMA Type 3**			
Does the patient have respiratory insufficiency? □ **YES** □ **NO** **Does the patient require gastric feeding tubes for the majority of feeds?** □ **YES** □ **NO** **Does the patient have severe contractures or severe scoliosis?** □ **YES** □ **NO** **Does the patient have wasting or cachexia?** □ **YES** □ **NO** **Does the patient experience issues with ambulating (SMA Type 3 only)?** □ **YES** □ **NO**			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

SPIRIVA RESPIMAT 1.25 MCG
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Spiriva Respimat 1.25 mcg must meet the following criteria:

- **Patient must have a diagnosis of asthma.**
- **Requires step therapy. Please see criteria for coverage.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Please list all medications patient has tried:**		
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Statins
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that who are prescribed a name-brand statin must first try a generic statin.

- *Requires step therapy. See statin criteria for more information.*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
QUALIFICATIONS FOR COVERAGE:			
Requested Drug and Dosage:	Diagnosis for this request:		
Medication Failed and Dose (list all)			
Is the statin intensity treatment goal low, moderate, or high? _____			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Steroid Inhalers
Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for a steroid inhaler must first try a 30-day trial of all preferred agents in the past year.

- **Requires a trial and failure of all preferred agents in the past year**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
QUALIFICATIONS FOR COVERAGE:			
Requested Drug and Dosage:		Diagnosis for this request:	
Failed Therapy (list all):		Start Date: End Date:	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

SYNAGIS WEB BASED FORM

For questions regarding this Prior Authorization Call 701-328-4023

Prior Authorization Vendor for ND Medicaid

Note:

- Synagis season will be October 19th through April 21st
- Providers will choose when to start dosing Synagis based on prevalence of RSV in the community
- Clinicians may administer up to a maximum of 5 monthly doses during the RSV season.
- Qualifying infants born during the RSV season may require fewer doses.

TO BE COMPLETED BY PRESCRIBER

Recipient Medicaid ID Number	Recipient Date of Birth	Prescriber NPI	Prescriber Fax Number
Billing Facility NPI	**Billing Facility Name**		**ICD-10 code**

Diagnosis (qualification for Synagis)

___ **Prematurity**

<29 weeks, 0 days gestational age – Synagis allowed if younger than 12 months of age at start of RSV season (max of 5 doses)

Gestational Age (e.g. 28 weeks, 4 days)

Weeks _____ **Days** _____

___ **Chronic Lung Disease of Prematurity (CLD)** – Child ≤12 months old with gestational age <32 weeks, 0 days and requires supplemental oxygen >21% for at least the first 28 days after birth.

___ **Chronic Lung Disease of Prematurity (CLD**) – Child ≤24 months old with gestational age <32 weeks, 0 days and requires supplemental oxygen >21% for at least the first 28 days after birth and continues to receive medical support within six months before the start of RSV season.

___ Supplemental Oxygen

___ Diuretic

___ Chronic corticosteroid therapy

___ **Congenital Heart Disease (CHD)**

Child ≤12 months old with hemodynamically significant cyanotic or acyanotic CHD

Medical Therapy Required _____

*children less than 24 months who undergo cardiac transplantation during RSV season may be considered for prophylaxis.

___ **Neuromuscular disease** (may be considered for prophylaxis during the first year of life)

___ **Pulmonary abnormalities** (may be considered for prophylaxis during the first year of life)

___ **Profoundly Immunocompromised children** (children <24 months of age may be considered for prophylaxis during the RSV season)

***Accessed online at pediatrics.aappublications.org**

health information designs

Tecfidera PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed Tecfidera must follow these guidelines:
Note:

- ***Must have relapsing forms of multiple sclerosis.***
- ***Must have a recent CBC (within 6 months).***
- ***Requires step therapy. See Tecfidera criteria for more information.***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist Involved in Therapy		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Tecfidera**	**Diagnosis for this request:** **Current CBC (date):**		
List all failed medications:	**Start Date:**	**End Date:**	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

TOPICAL TESTOSTERONE PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for a topical testosterone must meet the following criteria:

- **Patient must have an FDA approved indication.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**Diagnosis for this Request:**
□ ANDRODERM_____ □ ANDROGEL_____ □ FORTESTA_____ □ TESTIM_____ □ AXIRON_____ □ VOGELXO_____	**Testosterone Level:** **Date:**

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

List all failed medications:	**Start Date:**	**End Date:**
Prescriber (or Staff) / Pharmacy Signature**	Date	

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

TETRACYCLINE PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for a tetracycline must meet the following criteria:

- **Requires step therapy. Please see criteria for coverage.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: **Diagnosis:**	**Please list all medications patient has tried:**		
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

CYTOKINE MODULATORS PA FORM

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for Actemra, Cimzia, Cosentyx, Enbrel, Humira, Kevzara, Kineret, Orencia, Otezla, Siliq, Simponi, Stelara, Taltz, Tremfya, Xeljanz, and Xeljanz XR and must meet the following criteria:

- All agents will require an FDA-approved indication.
- For non-preferred agents, the patient must have had a 3-month trial with at least 2 preferred agents, as evidenced by paid claims or pharmacy print-outs.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Diagnosis for this request:			

Requested Drug and Dosage:			**List all failed medications:**	**Start Date:**	**End Date:**
□ ACTEMRA	□ CIMZIA	□ COSENTYX	□ ENBREL		
□ ENBREL	□ HUMIRA	□ HUMIRA PSORIASIS	□ HUMIRA		
□ KEVZARA	□ KINERET	□ ORENCIA	□ COSENTYX		
□ OTEZLA	□ SILIQ	□ SIMPONI	□ OTHER		
□ STELARA	□ TALTZ	□ TREMFYA			
□ XELJANZ		□ XELJANZ XR			

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

TIROSINT PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Tirosint must meet one of the following criteria:

- **Patient must have documented celiac disease, yellow dye allergy, or lactose/milk protein allergy.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		
List all failed medications (drug name, date of trial, reason for failure):			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

LOCAL ANESTHETICS (TOPICAL) PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for topical local anesthetic must meet the following criteria:

- **These medications will only be covered when prescribed for use prior to certain procedures (e.g., placement of a peripheral or central line or injections through an implanted port). Medical procedure must be listed on PA form.**
- **PA not required for patients 12 years of age and younger.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ Lidocaine-prilocaine topical □ Lidocaine-tetracaine topical	**FDA approved indication for this request:** □ Placement of a peripheral or central line □ Injections through an implanted port □ Other:		
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

TOPICAL ANTIPSORIATICS PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for topical antipsoriatics must meet the following criteria:

- **Calcipotriene cream and foam – Patient must have a 30-day trial of calcipotriene ointment or solution.**
- **Calcipotriene/betamethasone foam – Patient must have a 30-day trial of calcipotriene/betamethasone ointment or solution.**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number		
Prescriber Name				
Prescriber NPI	Telephone Number	Fax Number		
Address	City	State	Zip Code	
Requested Drug and Dosage:	**Diagnosis for Request:**			
Qualifications for Coverage:				
Medications patient has tried:	Start Date:	End Date:	Dose:	Frequency:
Other medical justification for use (why patient is unable to use ointment or solution of the requested product):				
Prescriber (or Staff) / Pharmacy Signature**		Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*				

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:		ND MEDICAID PROVIDER NUMBER:
Phone:		FAX:
Drug:		NDC#:

health information designs

Topical Ketoconazole Products PA Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed Extina, Xolegel, and Ketocon Plus must first try a covered ketoconazole medication.

Note:

- ***Ketoconazole creams and ketoconazole shampoos do not require a prior authorization.***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Extina** □ **Xolegel** □ **Ketocon Plus**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Medication Failed _____	Start Date: End Date:	Dose: Frequency:	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Serotonin (5-HT$_1$) Receptor Agonists - Triptan PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for a triptan must meet the following criteria:

- **Patients 6-17 must have a 30 day trial of rizatriptan in the past 24 months.**
- **Patients 18 years and older must have a 30 day trial of all preferred agents in the past 24 months.**
- **Sumatriptan tablets, Relpax, rizatriptan tablets, and rizatriptan ODT do not require a PA**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name		Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name				
Prescriber NPI		Telephone Number	Fax Number	
Address		City	State	Zip Code
Requested Drug and Dosage:		**Diagnosis for this request:** **Does patient have menstrual migraine?** **Is patient's migraine long in duration and does it recur?**		
□ Failed therapy	Start Date	End Date	Dose	Frequency
List all failed medications:		**Start Date:**	**End Date:**	
Prescriber (or Staff) / Pharmacy Signature**			Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*				

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

TYSABRI PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

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

- **Patient must have a confirmed diagnosis of multiple sclerosis or Crohn's disease.**
- **Requires step therapy. See Tysabri criteria for more information.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ TYSABRI	**FDA approved indication for this request:**		

• **Has patient experienced a reduction in relapse rate? (renewal requests)**	□ YES	□ NO
• **Has the patient had persistent positive anti-natalizumab antibody titers (2 consecutive positive tests 4 weeks or more apart) (renewal requests)**	□ YES	□ NO
• **Has patient had anti-JCV antibodies taken?**	□ YES	□ NO
• **Has patient had a MRI scan?**	□ YES	□ NO
• **Is the patient experiencing early aggressive disease? (>=2 relapses in the year and >= 1 Gadolinium (Gd)+ lesion)?**	□ YES	□ NO

List all failed medications:	**Start Date:**	**End Date:**
Prescriber (or Staff) / Pharmacy Signature**		Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

VANOS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Vanos must meet the following criteria:

- **Patient must be 12 years of age and older.**
- **Patient must have documented 3-month trial and failure with generic topical clobetasol or halobetasol.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ VANOS	**Diagnosis for this Request:**		
Failed Therapy (dose and frequency): □	**Start Date:** **End Date:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

VECAMYL
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Vecamyl must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Patient must have documented history of failure to achieve blood pressure goals (using maximum tolerated doses of all first and second line agents) as defined by the most recent JNC report.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name	Specialist Involved in Therapy		
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ VECAMYL	**Diagnosis for this Request:**		
List all failed medications:	**Start Date:**	**End Date:**	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Xenical
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a prescription for Xenical must be seen by a dietician.
Note:

- ***Patient must have dietician evaluation attached to PA form including height and weight.***
- ***BMI must be equal to or greater than 40.***
- ***5% weight loss must be realized for continued approval (every 6 months).***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ XENICAL	**Diagnosis for this request:**		
□ Dietician evaluation attached	Height:	Weight:	BMI:
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

XIFAXAN PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Xifaxan must meet the following guidelines:

- Patient must be 12 years of age or older and have a diagnosis of traveler's diarrhea caused by noninvasive strains of E. coli. Patient must try ciprofloxacin, levofloxacin, OR norfloxacin before PA for Xifaxan will be approved.
- Patient must be 18 years of age or older and have a risk of recurrence of overt hepatic encephalopathy.
- Do not use in patients with diarrhea complicated by fever or blood in the stool or diarrhea due to pathogens other than E. coli.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ XIFAXAN	**Diagnosis for this request:** □ TRAVELER'S DIARRHEA: 200 mg three times a day for 3 days □ HEPATIC ENCEPHALOPATHY: 550 mg two times a day		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Xyrem Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed Xyrem must meet these guidelines:
Note:

- ***Must be 18 years or older.***
- ***Must have a diagnosis of excessive daytime sleepiness and cataplexy in patients with narcolepsy.***
- ***Must be enrolled in the Xyrem REMS Program***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Xyrem**	**Diagnosis for this request:**	**List failed medication:**	

Qualifications for coverage:

□ Enrolled in Xyrem REMS Program Enrolled Date: Dose:

Is patient taking any sedative/hypnotics, opioids, or muscle relaxants? □ YES □ NO

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Zanaflex Capsule PA Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving Zanaflex capsules must use tizanidine tablets first line.
*__Note:__

- **Tizanidine tablets do not require a PA.**
- **Patient must fail therapy on tizanidine tablets before a PA may be granted.**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
Additional Qualifications for Coverage:			
□ Failed generic drug	Start Date: End Date:	Dose: Frequency:	
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

ZINBRYTA PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Zinbryta must meet the following criteria:

- **Patient must have a confirmed diagnosis of multiple sclerosis.**
- **Requires step therapy. See Zinbryta criteria for more details.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ ZINBRYTA	**FDA approved indication for this request:**		

• **Have transaminase and bilirubin levels been obtained in the last 6 months?**	□ YES	□ NO
• **Does patient have Hepatitis B or C?**	□ YES	□ NO
• **Has patient been screened for TB and treated for TB if positive?**	□ YES	□ NO
• **Is the patient experiencing early aggressive disease? (>=2 relapses in the year and >= 1 Gadolinium (Gd)+ lesion)?**	□ YES	□ NO
• **Has the patient had a reduction in relapse rate? (renewal requests)**	□ YES	□ NO

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Since the beginning of the year (2017), 67 people have overdosed on opioids, benzos, heroin, or an unspecified psychotropic drug.

Last 2 months of 2016 (Before Overdose)

13 were gets benzos or narcs paid by Medicaid

6 were getting benzos:

FDB Brand Name	Diagnosis
CLONAZEPAM 1 MG TABLET	T401X1A Poisoning by heroin, accidental, initial encounter
LORAZEPAM 1 MG TABLET	T402X2A Poisoning by other opioids, intentional self-harm, initial encounter
CLONAZEPAM 0.5 MG TABLET	T424X2A Poisoning by benzodiazepines, intentional self-harm, initial encounter
LORAZEPAM 1 MG TABLET	T401X1A Poisoning by heroin, accidental, initial encounter
CLONAZEPAM 1 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
ALPRAZOLAM 0.5 MG TABLET	T424X2A Poisoning by benzodiazepines, intentional self-harm, initial encounter

4 were getting narcotics: blue is same person

FDB Brand Name	Diagnosis
HYDROCODON-ACETAMINOPHEN 5-	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
OXYCODONE HCL 10 MG TABLET	T40604A Poisoning by unspecified narcotics, undetermined, initial encounter
TRAMADOL HCL 50 MG TABLET	T424X2A Poisoning by benzodiazepines, intentional self-harm, initial encounter
ACETAMINOPHEN-COD #3 TABLET	T402X1A Poisoning by other opioids, accidental, initial encounter
HYDROCODON-ACETAMINOPHEN 5-	T402X1A Poisoning by other opioids, accidental, initial encounter

3 were getting both:

ID	FDB Brand Name	Diagnosis
1	OXYCODONE-ACETAMINOPHEN 5-3	T424X2A Poisoning by benzodiazepines, intentional self-harm, initial encounter
1	CLONAZEPAM 0.5 MG TABLET	T424X2A Poisoning by benzodiazepines, intentional self-harm, initial encounter
1	HYDROCODON-ACETAMINOPHEN 5-	T424X2A Poisoning by benzodiazepines, intentional self-harm, initial encounter
2	HYDROCODON-ACETAMINOPHEN 5-	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
2	LORAZEPAM 1 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
2	CLONAZEPAM 1 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
3	OXYCODONE HCL 10 MG TABLET	T404X4A Poisoning by other synthetic narcotics, undetermined, initial encounter
3	FENTANYL 75 MCG/HR PATCH	T404X4A Poisoning by other synthetic narcotics, undetermined, initial encounter
3	CLONAZEPAM 0.5 MG TABLET	T404X4A Poisoning by other synthetic narcotics, undetermined, initial encounter

Last 2 months Aug-Sept 2017 (After Overdose *with 1 exception noted below)

8 were getting benzos

FDB Brand Name	Diagnosis
ALPRAZOLAM 0.5 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
CLONAZEPAM 1 MG TABLET	T401X1A Poisoning by heroin, accidental, initial encounter
CLONAZEPAM 0.125 MG DIS TAB	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
LORAZEPAM 1 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
ALPRAZOLAM 0.5 MG TABLET	T401X1A Poisoning by heroin, accidental, initial encounter
DIAZEPAM 5 MG TABLET	T424X2A Poisoning by benzodiazepines, intentional self-harm, initial encounter
LORAZEPAM 1 MG TABLET	T424X2A Poisoning by benzodiazepines, intentional self-harm, initial encounter ***This overdose was after lorazepam was dispensed**
CLONAZEPAM 1 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter

3 were getting narcotics

FDB Brand Name	Diagnosis
TRAMADOL HCL 50 MG TABLET	T40604A Poisoning by unspecified narcotics, undetermined, initial encounter
TRAMADOL HCL 50 MG TABLET	T424X2A Poisoning by benzodiazepines, intentional self-harm, initial encounter
OXYCODONE HCL 5 MG TABLET	T404X4A Poisoning by other synthetic narcotics, undetermined, initial encounter

1 was getting both

MMIS ID	FDB Brand Name	Diagnosis
1	TRAMADOL HCL 50 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
1	ALPRAZOLAM 2 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
1	LORAZEPAM 1 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter

Before and After overdose: 7 members on both lists

MMIS ID	Prior to overdose	After Overdose	Diagnosis
1	TRAMADOL HCL 50 MG TABLET	TRAMADOL HCL 50 MG TABLET	T424X2A Poisoning by benzodiazepines, intentional self-harm, initial encounter
2	CLONAZEPAM 0.5 MG TABLET	DIAZEPAM 5 MG TABLET	T424X2A Poisoning by benzodiazepines, intentional self-harm, initial encounter
3	CLONAZEPAM 1 MG TABLET	CLONAZEPAM 1 MG TABLET	T401X1A Poisoning by heroin, accidental, initial encounter
4	OXYCODONE HCL 10 MG TABLET	TRAMADOL HCL 50 MG TABLET	T40604A Poisoning by unspecified narcotics, undetermined, initial encounter
5	CLONAZEPAM 1 MG TABLET	CLONAZEPAM 1 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
6	HYDROCODON-ACETAMINOPHEN 5-	TRAMADOL HCL 50 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
6	LORAZEPAM 1 MG TABLET	ALPRAZOLAM 2 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
6	CLONAZEPAM 1 MG TABLET	LORAZEPAM 1 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
7	OXYCODONE HCL 10 MG TABLET	OXYCODONE HCL 5 MG TABLET	T404X4A Poisoning by other synthetic narcotics, undetermined, initial encounter
7	FENTANYL 75 MCG/HR PATCH		T404X4A Poisoning by other synthetic narcotics, undetermined, initial encounter
7	CLONAZEPAM 0.5 MG TABLET		T404X4A Poisoning by other synthetic narcotics, undetermined, initial encounter

Plan for Benzo + Narcotic Edit

All Benzos = Solid forms of Alprazolam, diazepam, clonazepam, lorazepam

Step 1: 6/9 66%
oxycodone ER, liquid Tylenol/Codeine, tramadol ER, Tylenol #2 & #4; Codeine; Nucynta IR,ER

Step 2: 17/23 people all different prescribers 74%
All benzos with:
Oxycodone 10-325mg

Step 3: 20/29 people all different prescribers 69%
All benzos with
Oxycodone 5-325mg

Step 4: 50/69 people all different prescribers 72%
Hydrocodone 5-325mg

a. 20/27 Alprazolam 1mg, 2mg; clonazepam 2mg; diazepam 5mg, 10mg
b. 20/27 alprazolam 0.25mg, 0.5mg; clonazepam 1mg; lorazepam 1mg
c. 10/15 the rest

Step 5: 28/45 people all different prescribers 62%
Hydrocodone 10-325mg

a. 8/16 – diazepam 5mg, 10mg; alprazolam 1mg; lorazepam 2mg; clonazepam 2mg
b. 20/29 – the rest

Step 6: 11/18 people different prescribers 61%
All benzos with:
Hydromorphone 2mg and over
Oxycodone 10mg and over

Step 7: 11/16 people all different prescribers 69%
All benzos with
Tylenol #3

Step 9: 12/25 people all different prescribers 48%
All benzos with
Oxycodone 5mg

Step 8: 40/84 people different prescribers 48%
Tramadol 50mg & Tramadol-acetaminophen

a. 18/28 Diazepam 5mg, 10mg; alprazolam 1mg, 2mg; lorazepam 2mg; clonazepam 2mg

b. 12/27 alprazolam 0.5mg; lorazepam 1mg
c. 10/23 lorazepam 0.5mg; clonazepam 1mg
d. 2/7 clonazepam 0.5mg, alprazolam XR, alprazolam 0.25mg

Step 10: 11/16 69%
All benzos with
Fentanyl patch

Step 11: 12/24 50%
All benzos with
Morphine IR + ER

PRODUCT DETAILS OF EUCRISA (crisaborole)

INDICATIONS AND USE:

- Treatment of topical treatment of mild to moderate atopic dermatitis in patients 2 years and older.

DOSAGE AND ADMINISTRATION:

- Apply thin film to affected area(s) twice daily.

DOSAGE FORM AND STRENGTHS:

- 2% External ointment in 60 gram tubes

CONTRAINDICATIONS:

- Hypersensitivity to crisaborole or any component of the formulation

WARNINGS AND PRECAUTIONS:

- Hypersensitivity to crisaborole or any component of the formulation

ADVERSE REACTIONS:

- Application site pain (4%).
- Hypersensitivity reaction, urticaria (<1%)

COST

- WAC Package Price: $580.00

CURRENT UTILIZATION

ND Medicaid Eucrisa Utilization (08/2017-09/2017)		
Label Name	**Rx Num**	**Total Reimb Amt**
EUCRISA	9	$ 4,249.51

REFERENCES:

1. Facts & Comparisons eAnswers. Available at http://online.factsandcomparisons.com. Accessed on October 31, 2017.
2. Eucrisa (crisaborole) [prescribing information]. Palo Alto, CA: Anacor Pharmaceuticals Inc; October 2017

PRODUCT DETAILS OF SKELAXIN (metaxalone)

INDICATIONS AND USE:

- Relief of discomforts associated with acute, painful musculoskeletal conditions.

DOSAGE AND ADMINISTRATION:

- 13 years of age and older:
  - 800 mg 3-4 times daily
- <12 years of age
  - Safety and efficacy have not been stablished

DOSAGE FORM AND STRENGTHS:

- 400 mg and 800 mg oral tablets

CONTRAINDICATIONS:

- Hypersensitivity to metaxalone or any component of the formulation
- Significantly impaired hepatic or renal function
- Tendency for drug-induced, hemolytic, or other anemias

WARNINGS AND PRECAUTIONS:

- **Serotonin Syndrome**: Potentially life-threatening serotonin syndrome has been reported; generally occurs when used concomitantly with serotonergic drugs or when exceeding recommended doses
- **Renal Impairment**: Use with caution in patients with renal impairment; contraindicated in patients with significant impairment
- **Hepatic Impairment**: Use with caution in patients with hepatic impairment; contraindicated in patients with significant hepatic impairment. Routine monitoring of transaminases is recommended
- **Drug/Drug Interactions**: Potentially significant interactions may occur when used with other CNS depressants

ADVERSE REACTIONS:

- The most common adverse effects noted during clinical trials were Dizziness, drowsiness, headache, irritability, nervousness, Gastrointestinal upset, nausea, and vomiting.
- Rare, but serious adverse reactions include anaphylactoid reaction, hypersensitivity reactions, hemolytic anemia, leukopenia, and Jaundice.

COST

- WAC unit price for 800 mg tablets: $9.29

CURRENT UTILIZATION

ND Medicaid Skelaxin Utilization (08/2017-09/2017)		
Label Name	**Rx Num**	**Total Reimb Amt**
SKELAXIN	34	$ 4,513.87

REFERENCES:

1. Facts & Comparisons eAnswers. Available at http://online.factsandcomparisons.com. Accessed on October 31, 2017.
2. Skelaxin (metaxalone) [prescribing information]. New York, NY: Pfizer; April 2017.

NORTH DAKOTA MEDICAID
RETROSPECTIVE DRUG UTILIZATION REVIEW
CRITERIA RECOMMENDATIONS
4TH QUARTER 2017

Criteria Recommendations ***Approved Rejected***

1. Safinamide / Overutilization _____ _____

Alert Message: Xadago (safinamide) may be over-utilized. The manufacturer's recommended maximum dose of safinamide is 100 mg once daily. Daily dosages of safinamide above 100 mg have not been shown to provide additional benefit, and higher dosages increase the risk for adverse reactions. Selectivity for MAO-B inhibition decreased in a dose-related manner above the highest recommended daily dosage.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negate)**
Safinamide		Hepatic Impairment

Max Dose: 100 mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

2. Safinamide / Hepatic Impairment _____ _____

Alert Message: The recommended maximum daily dose of Xadago (safinamide) in patients with moderate hepatic impairment (Child-Pugh B score 7-9), is 50 mg once daily. Safinamide use is contraindicated in patients with severe hepatic impairment (Child-Pugh C score 10-15). As a patient taking 50 mg safinamide progresses from moderate to severe hepatic impairment, discontinue safinamide.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Safinamide		Hepatic Impairment

Max Dose: 50 mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

3. Safinamide / Severe Hepatic Impairment _____ _____

Alert Message: Xadago (safinamide) use is contraindicated in patients with severe hepatic impairment (Child-Pugh C score 10-15). In clinical studies subjects with moderate hepatic impairment (Child-Pugh B) receiving safinamide had an approximate 80% increase in safinamide exposure.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Safinamide		Severe Hepatic Impairment

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

4. Safinamide / Levodopa/Carbidopa _____ _____

Alert Message: A review of the patient's drug history does not show a concurrent prescription for levodopa/carbidopa. Xadago (safinamide) is indicated as adjunctive treatment to levodopa/carbidopa in patients with Parkinson's disease (PD) experiencing "off" episodes. Safinamide has not been shown to be effective as monotherapy for the treatment of PD.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Negate)**
Safinamide		Levodopa/Carbidopa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

5. Safinamide / MAO Inhibitors _____ _____

Alert Message: Xadago (safinamide) is contraindicated for use with other drugs in the MAO inhibitor class or other drugs that are potent inhibitors of monoamine oxidase. Co-administration increases the risk of nonselective MAO inhibition, which may lead to hypertensive crisis. At least 14 days should elapse between discontinuation of safinamide and initiation of treatment of other MAOIs.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Safinamide	Isocarboxazid	
	Phenelzine	
	Tranylcypromine	
	Linezolid	
	Rasagiline	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

6. Safinamide / Opioids _____ _____

Alert Message: Concurrent use of Xadago (safinamide), a MAO-B inhibitor, with opioid drugs is contraindicated. Serious, sometimes fatal reactions have been precipitated with concomitant use of MAOIs and opioids. At least 14 days should elapse between discontinuation of safinamide and initiation of treatment with an opioids.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Safinamide	Meperidine	Fentanyl	
	Methadone	Dihydrocodeine	
	Morphine	Tapentadol	
	Codeine	Tramadol	
	Hydrocodone	Oxymorphone	
	Hydromorphone	Oxycodone	
	Levorphanol		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

7. Safinamide / Dextromethorphan _____ _____

Alert Message: The concurrent use of Xadago (safinamide), a MAO-B inhibitor, with a dextromethorphan-containing agent is contraindicated. The co-administration of dextromethorphan and MAOIs has been shown to cause episodes of psychosis or bizarre behavior.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Safinamide	Dextromethorphan	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

8. Safinamide / Serotonergic Agents _____ _____

Alert Message: The concurrent use of Xadago (safinamide), a MAO-B inhibitor, with a serotonergic drug is contraindicated. The co-administration of MAOIs and a serotonergic agent may result in potentially life-threatening serotonin syndrome. At least 14 days should elapse between discontinuation of safinamide and initiation of treatment with these drugs.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Safinamide	SNRIs	
	TCAs	
	Tetracyclic Antidepressants	
	Trazodone	
	Cyclobenzaprine	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

9. Safinamide / Sympathomimetic Agents _____ _____

Alert Message: The concurrent use of Xadago (safinamide), a MAO-B inhibitor, with a sympathomimetic agent is contraindicated. Hypertensive crisis has been reported in patients taking the recommended doses of selective MAO-B inhibitors and sympathomimetic medications.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Safinamide	Methylphenidate	
	Dexmethylphenidate	
	Amphetamine	
	Dextroamphetamine	
	Methamphetamine	
	Lisdexamfetamine	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

10. Safinamide / SSRIS _____ _____

Alert Message: Caution should be exercised when Xadago (safinamide), a MAO-B inhibitor, is co-administered with selective serotonin re-uptake inhibitors (SSRIs). In clinical trials, serotonin syndrome was reported in a patient treated with safinamide and an SSRI. In a patient treated with concomitant safinamide and an SSRI, use the lowest effective dose of the SSRI and monitor the patient for symptoms of serotonin syndrome.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Safinamide	Fluoxetine	Escitalopram	
	Paroxetine	Sertraline	
	Fluvoxamine	Vortioxetine	
	Citalopram	Vilazodone	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

11. Safinamide / BCRP Substrates _____ _____

Alert Message: Concurrent use of Xadago (safinamide) with a drug that is a BCRP substrate may result in increased plasma concentrations of the BCRP substrate. Safinamide and its major metabolite inhibit BCRP transport. If co-administration with safinamide and the BCRP substrate is warranted monitor the patient for increased pharmacologic or adverse effect of the BCRP substrate.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Safinamide	Methotrexate	
	Imatinib	
	Irinotecan	
	Lapatinib	
	Rosuvastatin	
	Sulfasalazine	
	Topotecan	
	Dantrolene	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

12. Safinamide / Dopamine Antagonists _____ _____

Alert Message: Concomitant use of Xadago (safinamide) with a dopamine antagonist may decrease the effectiveness of safinamide and exacerbate the symptoms of Parkinson's disease.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Safinamide	Antipsychotics	
	Metoclopramide	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

13. Safinamide / Nonadherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Xadago (safinamide). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Conflict Code: LR - Nonadherence
Drugs/Diseases

Util A	Util B	Util C
Safinamide		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005; 353:487- 497.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.
Richy FF, Pietri G, Morna KA et al. Compliance with Pharmacotherapy and Direct Healthcare Costs in Patients with Parkinson's Disease: A Retrospective Claims Database Analysis. Appl Health Ecom Health Policy (2013) 11:395-406.
Fleisher JE, Stern MB. Medication Non-Adherence in Parkinson's Disease. Curr Neuro Neurosci Rep. 2013 October;13(10).

14. Deutetrabenazine / Depression & Suicidality _____ _____

Alert Message: Austedo (deutetrabenazine) is contraindicated in patients who are actively suicidal, or who have depression which is untreated or undertreated.

Conflict Code: MC – Drug (Actual) Disease Warning
Drugs/Diseases

Util A	Util B	Util C
Deutetrabenazine	Depression – in partial or unspecified remission Suicidal Ideation	

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Austedo Prescribing Information, April 2017, Teva Pharmaceuticals.

15. Deutetrabenazine / Depression _____ _____

Alert Message: Caution should be exercised when prescribing Austedo (deutetrabenazine) to patients with a history of depression or prior suicide attempts or ideation. Patients with Huntington's disease are at increased risk for depression, suicidal ideation or behavior. Deutetrabenazine use is associated with risk of or worsening of depression and suicidality.

Conflict Code: MC – Drug (Actual) Disease Warning
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Deutetrabenazine		Depression in Remission

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Austedo Prescribing Information, April 2017, Teva Pharmaceuticals.

16. Deutetrabenazine / Hepatic Impairment _____ _____

Alert Message: Austedo (deutetrabenazine) use is contraindicated in patients with impaired hepatic function due to the potential for increased deutetrabenazine exposure and greater risk for serious adverse reactions. The effect of hepatic impairment on the pharmacokinetics of deutetrabenazine has not been studied; however in a clinical study conducted with tetrabenazine, a closely related VMAT2 inhibitor, there was a large increase in exposure to tetrabenazine and its active metabolites in patients with hepatic impairment.

Conflict Code: MC – Drug (Actual) Disease Warning
Drugs/Diseases

Util A	Util B	Util C
Deutetrabenazine	Hepatic Impairment	

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Austedo Prescribing Information, April 2017, Teva Pharmaceuticals.

17. Deutetrabenazine / MAOIs _____ _____

Alert Message: Austedo (deutetrabenazine) is contraindicated in patients taking MAOIs. Deutetrabenazine should not be used in combination with or within a minimum of 14 days of discontinuing therapy with an MAOI. Concurrent use may result in hypertensive crisis due to depletion of monoamines (dopamine, serotonin, norepinephrine, and histamine) from nerve terminals.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Deutetrabenazine	Isocarboxazid	
	Phenelzine	
	Tranylcypromine	
	Linezolid	
	Selegiline	
	Rasagiline	

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Austedo Prescribing Information, April 2017, Teva Pharmaceuticals.

18. Deutetrabenazine / Reserpine _____ _____

Alert Message: Concurrent use of Austedo (deutetrabenazine) with reserpine is contraindicated due to the potential for significant depletion of serotonin and norepinephrine in the CNS. At least 20 days should elapse after stopping reserpine before starting deutetrabenazine.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Deutetrabenazine	Reserpine	

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Austedo Prescribing Information, April 2017, Teva Pharmaceuticals.

19. Deutetrabenazine / Tetrabenazine _____ _____

Alert Message: Concurrent use of Austedo (deutetrabenazine) with tetrabenazine is contraindicated. Deutetrabenazine therapy may be initiated the day following discontinuation of tetrabenazine. Both deutetrabenazine and tetrabenazine are VMAT2 inhibitors and concomitant use may cause synergistic or additive toxicity.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Deutetrabenazine	Tetrabenazine	

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Austedo Prescribing Information, April 2017, Teva Pharmaceuticals.

20. Deutetrabenazine / Strong CYP2D6 Inhibitor _____ _____

Alert Message: The concurrent use of Austedo (deutetrabenazine) with a strong CYP2D6 inhibitor (e.g., fluoxetine, paroxetine, and quinidine) may markedly increase the exposure to the active metabolites of deutetrabenazine (approximately 3-fold). The total dose of deutetrabenazine should not exceed 36 mg per day in these patients. The maximum single dose should not exceed 18 mg.

Conflict Code: HD – High Dose
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Deutetrabenazine		Paroxetine
		Fluoxetine
		Quinidine
		Bupropion

Max Dose: 36 mg/day

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Austedo Prescribing Information, April 2017, Teva Pharmaceuticals.

21. Deutetrabenazine / CNS Depressants _____ _____

Alert Message: The concurrent use of Austedo (deutetrabenazine) with CNS depressants including alcohol may have additive effects and worsen sedation and somnolence.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Deutetrabenazine	Sedatives/Hypnotics	
	Benzodiazepines	
	Narcotics	

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Austedo Prescribing Information, April 2017, Teva Pharmaceuticals.

22. Deutetrabenazine / Dopamine Antagonists _____ _____

Alert Message: The concurrent use of Austedo (deutetrabenazine), a dopamine depleting agent, with dopamine antagonists may result in increased risk for parkinsonism, NMS, and akathisia.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Deutetrabenazine	Antipsychotics	
	Metoclopramide	
	Amoxapine	

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Austedo Prescribing Information, April 2017, Teva Pharmaceuticals.

23. Deutetrabenazine / QTc Prolongation, Arrhythmias, Bradycardia Hypokalemia & Hypomagnesemia _____ _____

Alert Message: Austedo (deutetrabenazine) use should be avoided in patients with congenital long QT syndrome, cardiac arrhythmias, or history of hypokalemia or hypomagnesemia. At 24 mg, deutetrabenazine has been shown to cause an approximate 4.5 msec mean increase in the QTc.

Conflict Code: MC – Drug (Actual) Disease Warning
Drugs/Diseases

Util A	Util B	Util C
Deutetrabenazine	Long QT Syndrome	
	Arrhythmias	
	Bradycardia	
	Hypokalemia	
	Hypomagnesemia	

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Austedo Prescribing Information, April 2017, Teva Pharmaceuticals.

24. Deutetrabenazine / Overutilization _____ _____

Alert Message: The manufacturer's recommended maximum total daily dose of Austedo (deutetrabenazine) is 48 mg (24 mg twice daily). The maximum daily dose in patients who are poor CYP2D6 metabolizers is 36 mg (18 mg twice daily). Administer total daily dosages of 12 mg or above in two divided doses.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C **(Negate)**
Deutetrabenazine		Paroxetine
		Fluoxetine
		Quinidine
		Bupropion

Max Dose: 48 mg/day

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.

25. Deutetrabenazine / Medications Causing QT Prolongation _____ _____

Alert Message: The concurrent use of Austedo (deutetrabenazine) with medications that are known to prolong QTc should be avoided. At 24 mg, deutetrabenazine has been shown to cause an approximate 4.5 msec mean increase in the QTc.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B				Util C
Deutetrabenazine	Albuterol	Disopyramide	Imipramine	Pazopanib	Thioridazine
	Alfuzosin	Dofetilide	Indapamide	Pentamidine	Tizanidine
	Amantadine	Dolasetron	Isradipine	Pimozide	Tolterodine
	Amiodarone	Doxepin	Itraconazole	Posaconazole	Trazodone
	Amitriptyline	Dronedarone	Ketoconazole	Procainamide	TMP/SMZ
	Amphetamine	Droperidol	Lapatinib	Propafenone	Trimipramine
	Arsenic Trioxide	Ephedrine	Levalbuterol	Protriptyline	Vandetanib
	Asenapine	Epinephrine	Levofloxacin	Quetiapine	Vardenafil
	Atazanavir	Erythromycin	Lithium	Quinidine	Venlafaxine
	Atomoxetine	Escitalopram	Metaproterenol	Ranolazine	Ziprasidone
	Azithromycin	Felbamate	Methadone	Risperidone	Zolmitriptan
	Chloral Hydrate	Flecainide	Moexipril/HCTZ	Ritonavir	Ezogabine
	Chloroquine	Fluconazole	Moxifloxacin	Salmeterol	
	Chlorpromazine	Fluoxetine	Nicardipine	Saquinavir	
	Ciprofloxacin	Foscarnet	Nilotinib	Sertraline	
	Citalopram	Fosphenytoin	Norfloxacin	Solifenacin	
	Clarithromycin	Galantamine	Nortriptyline	Sotalol	
	Clomipramine	Gemifloxacin	Octreotide	Sunitinib	
	Clozapine	Granisetron	Ofloxacin	Tacrolimus	
	Dasatinib	Haloperidol	Ondansetron	Tamoxifen	
	Desipramine	Ibutilide	Paliperidone	Terbutaline	
	Diphenhydramine	Iloperidone	Paroxetine	Apomorphine	

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Austedo Prescribing Information, April 2017, Teva Pharmaceuticals.

26. Valbenazine / Overutilization _____ _____

Alert Message: Ingrezza (valbenazine) may be over-utilized. The manufacturer's recommended maximum daily dose of valbenazine is 80 mg once daily.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negating)**	
Valbenazine		Hepatic Impairment	Saquinavir
		Nefazodone	Ritonavir
		Clarithromycin	Indinavir
		Quinidine	Nelfinavir
		Ketoconazole	Cobicistat
		Itraconazole	Bupropion
		Voriconazole	Fluoxetine
		Posaconazole	Paroxetine

Max Dose: 80 mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

27. Valbenazine / Overutilization – Hepatic Impairment _____ _____

Alert Message: Ingrezza (valbenazine) may be over-utilized. The manufacturer's recommended maximum daily dose of valbenazine in patients with moderate to severe hepatic impairment (Child Pugh score 7 to 15) is 40 mg once daily.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Valbenazine		Hepatic Impairment

Max Dose: 40 mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

28. Valbenazine / Severe Renal Impairment _____ _____

Alert Message: Ingrezza (valbenazine) use is not recommended in patients with severe renal impairment (CrCl < 30 mL/min). Dosage adjustment is not necessary for patients with mild to moderate renal impairment (CrCl 30 to 90 mL/min).

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Valbenazine		CKD Stage 4, 5, & ESRD

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

29. Valbenazine / CYP3A4 Inducers _____ _____

Alert Message: Concurrent use of Ingrezza (valbenazine) with strong CYP3A4 inducers is not recommended. Valbenazine is a CYP3A4 substrate and co-administration with a strong CYP3A4 inducer may result in decreased exposure to valbenazine and its active metabolite reducing efficacy.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Valbenazine	Carbamazepine	Rifampin	
	Phenytoin	Rifabutin	
	Phenobarbital	Rifapentine	
	Primidone	Enzalutamide	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

30. Valbenazine / MAO Inhibitors _____ _____

Alert Message: Concurrent use of Ingrezza (valbenazine), a VMAT2 inhibitor, with a MAO inhibitor should be avoided. Co-administration of these agents may result in increased concentrations of monoamine neurotransmitters in synapses, potentially leading to increased risk of adverse reactions such as serotonin syndrome or attenuated treatment effect of valbenazine.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Valbenazine	Isocarboxazid	
	Phenelzine	
	Tranylcypromine	
	Selegiline	
	Linezolid	
	Rasagiline	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

31. Valbenazine / Strong CYP3A4 Inhibitors _____ _____

Alert Message: Concurrent use of Ingrezza (valbenazine), a CYP3A4 substrate, with a strong CYP3A4 inhibitor may result in increased exposure to valbenazine and its active metabolite. Concomitant use may put the patient at risk for valbenazine exposure-related adverse reactions. The manufacturer recommends reducing the dose of valbenazine to 40 mg once daily when valbenazine is co-administered with a strong CYP3A4 inhibitor.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**	
Valbenazine		Nefazodone	Saquinavir
		Clarithromycin	Ritonavir
		Ketoconazole	Indinavir
		Itraconazole	Nelfinavir
		Voriconazole	Cobicistat
		Posaconazole	

Max Dose: 40 mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

32. Valbenazine / Strong CYP2D6 Inhibitors _____ _____

Alert Message: Concurrent use of Ingrezza (valbenazine), a CYP2D6 substrate, with a strong CYP2D6 inhibitor may result in increased exposure to valbenazine and its active metabolite. Concomitant use may put the patient at risk for valbenazine exposure-related adverse reactions. Consider reducing the valbenazine dose based on tolerability when valbenazine is co-administered with a strong CYP2D6 inhibitor.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Valbenazine	Bupropion	
	Paroxetine	
	Fluoxetine	
	Quinidine	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

33. Valbenazine / Digoxin _____ _____

Alert Message: Concurrent use of Ingrezza (valbenazine) with digoxin, a P-gp substrate, may result in increased digoxin levels due to inhibition, by valbenazine, of digoxin P-gp mediated transport. Digoxin concentrations should be monitored when co-administering these agents. Dosage adjustment of digoxin may be necessary.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Valbenazine	Digoxin	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

34. Valbenazine / QT Prolongation, Arrhythmias, Bradycardia _____ _____

Alert Message: Ingrezza (valbenazine) use should be avoided in patients with congenital long QT syndrome or with arrhythmias associated with a prolonged QT interval.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Valbenazine		Long QT Syndrome
		Arrhythmias

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

35. Valbenazine / Pregnancy / Pregnancy Negating _____ _____

Alert Message: The limited available data on Ingrezza (valbenazine) use in pregnant women is insufficient to inform a drug-associated risk. In animal studies no malformations were observed when valbenazine was administered to rats and rabbits during the period of organogenesis at doses up to 24 times the maximum recommended human dose. However, administration of valbenazine to pregnant rats during organogenesis through lactation produced an increase in the number of stillborn pups and postnatal pup mortalities. Advise pregnant females of potential risk to fetus.

Conflict Code: MC – Drug (Actual) Disease Warning
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Valbenazine	Pregnancy	Delivery
		Miscarriage
		Abortion

Gender: Female
Age Range: 11 – 55 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

36. Valbenazine / Medications Causing QT Prolongation _____ _____

Alert Message: The concurrent use of Ingrezza (valbenazine) with medications that are known to prolong QTc should be avoided. Valbenazine may cause an increase in the QT interval and use with other agents that also prolong the interval may have an additive effect.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B				Util C
Valbenazine	Albuterol	Disopyramide	Imipramine	Pazopanib	Thioridazine
	Alfuzosin	Dofetilide	Indapamide	Pentamidine	Tizanidine
	Amantadine	Dolasetron	Isradipine	Pimozide	Tolterodine
	Amiodarone	Doxepin	Itraconazole	Posaconazole	Trazodone
	Amitriptyline	Dronedarone	Ketoconazole	Procainamide	TMP/SMZ
	Amphetamine	Droperidol	Lapatinib	Propafenone	Trimipramine
	Arsenic Trioxide	Ephedrine	Levalbuterol	Protriptyline	Vandetanib
	Asenapine	Epinephrine	Levofloxacin	Quetiapine	Vardenafil
	Atazanavir	Erythromycin	Lithium	Quinidine	Venlafaxine
	Atomoxetine	Escitalopram	Metaproterenol	Ranolazine	Ziprasidone
	Azithromycin	Felbamate	Methadone	Risperidone	Zolmitriptan
	Chloral Hydrate	Flecainide	Moexipril/HCTZ	Ritonavir	Ezogabine
	Chloroquine	Fluconazole	Moxifloxacin	Salmeterol	Apomorphine
	Chlorpromazine	Fluoxetine	Nicardipine	Saquinavir	Telotristat
	Ciprofloxacin	Foscarnet	Nilotinib	Sertraline	
	Citalopram	Fosphenytoin	Norfloxacin	Solifenacin	
	Clarithromycin	Galantamine	Nortriptyline	Sotalol	
	Clomipramine	Gemifloxacin	Octreotide	Sunitinib	
	Clozapine	Granisetron	Ofloxacin	Tacrolimus	
	Dasatinib	Haloperidol	Ondansetron	Tamoxifen	
	Desipramine	Ibutilide	Paliperidone	Terbutaline	
	Diphenhydramine	Iloperidone	Paroxetine	Deutetrabenazine	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

37. Valbenazine / Lactation & Disorders of Lactation _____ _____

Alert Message: There is no information regarding the presence of Ingrezza (valbenazine) or its active metabolites in human milk. Valbenazine and its metabolites have been detected in rat milk. Based on animal findings of increased perinatal mortality in exposed fetuses and pups, advise a woman to not breastfeed during treatment with valbenazine and for 5 days after the final dose.

Conflict Code: MC – Drug (Actual) Disease Warning
Drugs/Diseases

Util A	Util B	Util C
Valbenazine	Lactation	
	Disorder of Lactation	

Gender: Female
Age Range: 11 – 55 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

38. Itraconazole Caps / Avanafil _____ _____

Alert Message: Stendra (avanafil) is contraindicated for use during and for 2 weeks after itraconazole therapy. Co-administration of avanafil with itraconazole can result in elevated avanafil plasma concentrations and may increase or prolong the pharmacologic effects and adverse reactions to avanafil.

Conflict Code: DD – Drug/Drug Interactions
Drugs/Diseases

Util A	Util B	Util C
Itraconazole Caps	Avanafil	

References:
Sporanox Prescribing Information, October 2017, Janssen Pharmaceutical Companies.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.

39. Cobimetinib / Overutilization _____ _____

Alert Message: The manufacturer's recommended dose of Cotellic (cobimetinib) is 60 mg orally once daily for the first 21 days of each 28-day cycle.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Cobimetinib		

Max Dose: 60 mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Cotellic Prescribing Information, May 2016, Genentech.

40. Cobimetinib / Therapeutic Appropriateness _____ _____

Alert Message: Cotellic (cobimetinib) can cause fetal harm when administered to a pregnant woman. Advise females of reproductive potential to use effective contraception during treatment with cobimetinib and for 2 weeks following the final dose of cobimetinib.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Cobimetinib		

Gender: Female
Age Range: 11 - 50 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Cotellic Prescribing Information, May 2016, Genentech.

41. Cobimetinib / Overutilization _____ _____

Alert Message: The safety and effectiveness of Cotellic (cobimetinib) have not been established in pediatric patients.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Cobimetinib		

Age Range: ≥ 18 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Cotellic Prescribing Information, May 2016, Genentech.

42. Cobimetinib / Moderate to Strong CYP3A Inhibitors _____ _____

Alert Message: Concurrent use of Cotellic (cobimetinib) with strong or moderate CYP3A inhibitors should be avoided. If concurrent short term (14 days or less) use of moderate CYP3A inhibitors including certain antibiotics is unavoidable for patients who are taking cobimetinib 60 mg, reduce cobimetinib dose to 20 mg. After discontinuation of a moderate CYP3A inhibitor, resume cobimetinib at the previous dose. Use an alternative to a strong or moderate CYP3A inhibitor in patients who are taking a reduced dose of cobimetinib.

Conflict Code: DD – Drug/Drug interaction
Drugs/Diseases

Util A	Util B			Util C
Cobimetinib	Nefazodone	Atazanavir	Fluconazole	
	Clarithromycin	Darunavir	Cimetidine	
	Saquinavir	Tipranavir	Cyclosporine	
	Ritonavir	Ciprofloxacin	Erythromycin	
	Nelfinavir	Aprepitant	Idelalisib	
	Indinavir	Diltiazem	Fosamprenavir	
	Cobicistat	Verapamil	Clotrimazole	
	Ketoconazole	Imatinib		
	Itraconazole	Crizotinib		
	Voriconazole	Fluvoxamine		
	Posaconazole	Dronedarone		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Cotellic Prescribing Information, May 2016, Genentech.

43. Cobimetinib / Moderate to Strong CYP3A Inducers _____ _____

Alert Message: Concurrent use of Cotellic (cobimetinib) with strong or moderate CYP3A inducers should be avoided. Co-administration of cobimetinib with a strong CYP3A inducer may decrease cobimetinib systemic exposure by more than 80% and reduce its efficacy.

Conflict Code: DD – Drug/Drug interaction
Drugs/Diseases

Util A	Util B		Util C
Cobimetinib	Carbamazepine	Modafinil	
	Phenytoin	Bosentan	
	Phenobarbital	Efavirenz	
	Primidone	Etravirine	
	Rifabutin	Mitotane	
	Rifampin	Bexarotene	
	Rifapentine	Dabrafenib	
	Enzalutamide		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Cotellic Prescribing Information, May 2016, Genentech.

44. Rucaparib / Overutilization _____ _____
Alert Message: The manufacturer's recommended dose of Rubraca (rucaparib) is 600 mg taken orally twice daily.

Conflict Code: ER - Overutilization
Drugs/Diseases
Util A Util B Util C
Rucaparib

Max Dose: 1200 mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Rubraca Prescribing Information, Feb. 2017, Clovis Oncology, Inc.

45. Rucaparib / Therapeutic Appropriateness _____ _____
Alert Message: Rubraca (rucaparib) can cause fetal harm when administered to a pregnant woman. Advise females of reproductive potential to use effective contraception during treatment and for 6 months following the final dose of rucaparib. Pregnancy testing is recommended for females of reproductive potential prior to initiating rucaparib.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases
Util A Util B Util C
Rucaparib

Age Range: 11 - 50 yoa
Gender: Female

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Rubraca Prescribing Information, Feb. 2017, Clovis Oncology, Inc.

46. Rucaparib / Therapeutic Appropriateness _____ _____
Alert Message: The safety and effectiveness of Rubraca (rucaparib) in pediatric patients have not been established.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases
Util A Util B Util C
Rubraca

Age Range: ≥ 18 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Rubraca Prescribing Information, Feb. 2017, Clovis Oncology, Inc.

47. Deflazacort / Therapeutic Appropriateness 0 – 4 yoa _____ _____

Alert Message: The safety and effectiveness of Emflaza (deflazacort) for the treatment of Duchenne Muscular Dystrophy (DMD) in patients less than 5 years of age have not been established.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Deflazacort		

Age Range: 0 – 4 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Emflaza Prescribing Information, Feb. 2017, Marathon Pharmaceuticals, LLC.

48. Deflazacort / Moderate to Strong CYP3A4 Inhibitors _____ _____

Alert Message: Concurrent use of Emflaza (deflazacort), a CYP3A4 substrate, with a moderate or strong CYP3A4 inhibitor may result in increased total exposure to the active metabolite of deflazacort, 21-desDFZ. Therefore, give one third the recommended dosage of deflazacort when deflazacort is co-administered with moderate or strong CYP3A4 inhibitors.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Deflazacort	Nefazodone	Atazanavir	Fluconazole
	Clarithromycin	Darunavir	Cimetidine
	Saquinavir	Tipranavir	Cyclosporine
	Ritonavir	Ciprofloxacin	Erythromycin
	Nelfinavir	Aprepitant	Idelalisib
	Indinavir	Diltiazem	Fosamprenavir
	Cobicistat	Verapamil	Clotrimazole
	Ketoconazole	Imatinib	
	Itraconazole	Crizotinib	
	Voriconazole	Fluvoxamine	
	Posaconazole	Dronedarone	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Emflaza Prescribing Information, Feb. 2017, Marathon Pharmaceuticals, LLC.

49. Deflazacort / Moderate to Strong CYP3A4 Inducers _____ _____

Alert Message: Concurrent use of Emflaza (deflazacort) with a moderate to strong CYP3A4 inducer should be avoided. Deflazacort is a CYP3A4 substrate and concurrent use with a CYP3A4 inducer may significantly decrease the exposure of the active metabolite 21-desDFZ and reduce deflazacort efficacy.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Deflazacort	Carbamazepine	Modafinil	
	Phenytoin	Bosentan	
	Phenobarbital	Efavirenz	
	Primidone	Etravirine	
	Rifabutin	Mitotane	
	Rifampin	Bexarotene	
	Rifapentine	Dabrafenib	
	Enzalutamide		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Emflaza Prescribing Information, Feb. 2017, Marathon Pharmaceuticals, LLC.

50. Deflazacort / Behavioral & Mood Disturbances _____ _____

Alert Message: Potentially severe psychiatric adverse reactions may occur with systemic corticosteroids, including Emflaza (deflazacort). Symptoms typically emerge within a few days or weeks of starting treatment and may be dose-related. These reactions may improve after either dose reduction or withdrawal, although pharmacologic treatment may be necessary. Inform patient or caregivers of the potential for behavioral and mood changes and encourage them to seek medical attention if psychiatric symptoms develop, especially if depressed mood or suicidal ideation is suspected.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C
Deflazacort	Insomnia	
	Unspecified Mood Disorder	
	Depression	
	Mania	
	Irritability	
	Anxiety	
	Suicidal Ideation	
	Amnesia	
	Hallucinations	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Emflaza Prescribing Information, Feb. 2017, Marathon Pharmaceuticals, LLC.

51. Diphenoxylate/Atropine / Therapeutic Appropriateness _____ _____

Alert Message: Diphenoxylate/atropine is contraindicated in pediatric patients less than 6 years of age due to the risk of respiratory and central nervous system (CNS) depression. Cases of severe respiratory depression and coma, leading to permanent brain damage or death have been reported in patients less than 6 years of age who have received diphenoxylate/atropine.

Conflict Code: TA - **Therapeutic Appropriateness**
Drugs/Diseases

Util A	Util B	Util C
Diphenoxylate/Atropine		

Age Range: < 6 yoa

References:
Lomotil Prescribing Information, October 2017, Pfizer.

52. Diphenoxylate/Atropine / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of diphenoxylate/atropine have not been established in patients less than 13 years of age.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Diphenoxylate/Atropine		

Age Range: 6 - 12 yoa

References:
Lomotil Prescribing Information, October 2017, Pfizer.
Facts & Comparisons, 2017 Wolters Kluwer Health.

53. Diphenoxylate/Atropine / Obstructive Jaundice _____ _____
Alert Message: Diphenoxylate/atropine is contraindicated in patients with obstructive jaundice.

Conflict Code: MC – Drug (Actual) Disease Warning/Contraindication
Drugs/Diseases

Util A	Util B	Util C
Diphenoxylate/Atropine	Obstruction of the Bile Duct	

References:
Lomotil Prescribing Information, October 2017, Pfizer.
Facts & Comparisons, 2017 Wolters Kluwer Health.

54. Dexlansoprazole / Hepatic Impairment _____ _____
Alert Message: The maximum recommended dosage of Dexilant (dexlansoprazole) in patients with moderate hepatic impairment (Child-Pugh Class B) is 30 mg per day. In a study patients with moderate hepatic impairment who received a single dose of dexlansoprazole, exhibited approximately two times greater systemic exposure (AUC) compared to healthy subjects with normal hepatic function. Dexlansoprazole use is not recommended in patients with severe hepatic impairment. No dosage adjustment is necessary for mild hepatic impairment.

Conflict Code: ER – Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Dexlansoprazole		Hepatic Impairment

Max Dose: 30 mg/day

References:
Dexliant Prescribing Information, October 2017, Takeda Pharmaceuticals America, Inc.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.

55. Clindamycin / Strong CYP3A4 & CYP3A5 Inhibitors _____ _____
Alert Message: Concurrent use of clindamycin a CYP3A4/5 substrate, with a strong CYP3A4 or CYP3A5 inhibitor may result in increased clindamycin plasma concentrations. Monitor patient for clindamycin-related adverse events when co-administering clindamycin with strong 3A4/5 inhibitors.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Clindamycin	Nefazodone	Saquinavir	
	Clarithromycin	Ritonavir	
	Posaconazole	Indinavir	
	Ketoconazole	Nelfinavir	
	Itraconazole	Idelalisib	
	Voriconazole	Cobicistat	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Cleocin Prescribing Information, May 2017, Pfizer US.

56. Clindamycin / Strong CYP3A4 & CYP3A5 Inducers _____ _____

Alert Message: Concurrent use of clindamycin, a CYP3A4/5 substrate, with a strong CYP3A4 or CYP3A5 inducer may result in decreased clindamycin plasma concentrations. Monitor patient for loss of clindamycin efficacy.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Clindamycin	Phenytoin	Rifampin	
	Phenobarbital	Rifapentine	
	Primidone	Rifabutin	
	Carbamazepine	Enzalutamide	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Cleocin Prescribing Information, May 2017, Pfizer US.

57. Codeine / CYP2D6 Inhibitors _____ _____

Alert Message: Concurrent use of a codeine-containing agent with a CYP2D6 inhibitor may result in a decrease in the effects of codeine. Codeine must be bioactivated via CYP2D6 to morphine to exert an analgesic effect. Consider the use of an alternative analgesic for patients requiring therapy with an agent that is a CYP2D6 inhibitor.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Codeine	Fluoxetine	Propafenone	
	Paroxetine	Quinidine	
	Bupropion	Terbinafine	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017 Wolters Kluwer Health.

58. NNRTIs & Enfuvirtide / HIV-2 _____ _____

Alert Message: A review of the patient's records reveals that the patient has a diagnosis of HIV-2 and is receiving an NNRTI. HIV-2 is intrinsically resistant to non-nucleoside reverse transcriptase inhibitors (NNRITs) and to enfuvirtide thus these drugs should not be included in an antiretroviral regimen for an HIV-2 infected patient.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Delavirdine		HIV-2
Efavirenz		
Etravirine		
Nevirapine		
Rilpivirine		

References:
Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents. Department of Health and Human Services. July 14, 2016. Available at: http://www.aidsinfo.nih.gov/contentfiles/adultandadolescentgl.pdf.
Panel on Treatment of HIV-infected Pregnant Women and Prevention of Perinatal Transmission. Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States. October 26, 2016. Available at: http://aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf

59. NNRTIs & Enfuvirtide / HIV-2 _____ _____

Alert Message: A review of the patient's records reveals that the patient has a diagnosis of HIV-2 and is receiving enfuvirtide. HIV-2 is intrinsically resistant to enfuvirtide and to non-nucleoside reverse transcriptase inhibitors (NNRTIs) thus these drugs should not be included in an antiretroviral regimen for an HIV-2 infected patient.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Enfuvirtide		HIV-2

References:
Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents. Department of Health and Human Services. July 14, 2016. Available at: http://www.aidsinfo.nih.gov/contentfiles/adultandadolescentgl.pdf.
Panel on Treatment of HIV-infected Pregnant Women and Prevention of Perinatal Transmission. Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States. October 26, 2016. Available at: http://aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf

60. Voriconazole / Ergot Alkaloids _____ _____

Alert Message: Concurrent use of Vfend (voriconazole) with ergot alkaloids is contraindicated due to the risk of ergotism. Voriconazole is a strong CYP3A4 inhibitor and co-administration with an ergot alkaloid which is a CYP3A4 substrate can result in elevated substrate concentrations.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Voriconazole	Ergotamine	
	Dihydroergotamine	
	Methylergonovine	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017 Wolters Kluwer Health.

61. Voriconazole / Vinca Alkaloids _____ _____

Alert Message: Concurrent use of Vfend (voriconazole) with vinca alkaloids should be avoided due to the risk if increased vinca alkaloid plasm concentrations which may lead to vinca alkaloid-related neurotoxicity. Voriconazole is a strong CYP3A4 inhibitor and co-administration with a vinca alkaloid which is a CYP3A4 substrate can result in elevated substrate concentrations.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Voriconazole	Vincristine	
	Vinblastine	
	Vinorelbine	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017 Wolters Kluwer Health.

62. Voriconazole / Atazanavir / Ritonavir _____ _____

Alert Message: The use of Vfend (voriconazole) in patients receiving atazanavir/rtv is not recommended unless an assessment of the benefit/risk to the patient justified the use of voriconazole. If concomitant therapy cannot be avoided patients should be carefully monitored for voriconazole associated adverse reactions and loss of either voriconazole or atazanavir efficacy. Co-administration of voriconazole with atazanavir (without ritonavir) may affect atazanavir concentrations; however, do data are available.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Voriconazole	Atazanavir	Ritonavir

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017 Wolters Kluwer Health.

63. Selexipag / CYP2C8 Inhibitors _____ _____

Alert Message: Concurrent use of Uptravi (selexipag), a CYP2C8 substrate, with a moderate CYP2C8 inhibitor can be expected to increase exposure to the active metabolite of selexipag. Consider a less frequent dosing regimen, e.g., once daily, when initiating selexipag in patients on a CYP2C8 inhibitor. Reduce selexipag dose when a moderate CYP2C8 inhibitor is initiated.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Selexipag	Teriflunomide	
	Deferasirox	
	Lapatinib	
	Nilotinib	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017 Wolters Kluwer Health.
Uptravi Prescribing Information, July 2017, Actelion Pharmaceuticals US, Inc.

64. Methylphenidate XR-ODT / Overutilization _____ _____

Alert Message: The manufacturer's recommended maximum total daily dose of Cotempla XR-ODT (methylphenidate extended-release orally disintegrating) is 51.8 mg. Daily doses above 51.8 mg are not recommended.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Methylphenidate XR-ODT		

Max Dose: 51.8 mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Cotempla XR-ODT Prescribing Information, June 2017, Neos Therapeutics, Inc.

65. Dextroamphetamine/amphetamine ER Caps / Overutilization _____ _____
Alert Message: The manufacturer's recommended maximum total daily dose of Mydayis (dextroamphetamine/amphetamine), in adult patients, is 50 mg.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negate)**
Dextroamphetamine/amphetamine ER caps		CKD Stage 4 & 5

Max Dose: 50 mg/day
Age Range: ≥ 18 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Mydayis Prescribing Information, June 2017, Shire US, Inc.

66. Dextroamphetamine/amphetamine ER Caps /Severe Renal Impairment _____ _____
Alert Message: The manufacturer's recommended maximum total daily dose of Mydayis (dextroamphetamine/amphetamine), in adult patients with severe renal impairment (GFR 15 to < 30 ml/min/1.73m2), is 25 mg. Dextroamphetamine/amphetamine extended-release is not recommended for use in patients with end stage renal disease (ESRD < 15 ml/min/1.73m2).

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Dextroamphetamine/amphetamine ER caps		CKD Stage 4 & 5

Max Dose: 25 mg/day
Age Range: ≥ 18 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Mydayis Prescribing Information, June 2017, Shire US, Inc.

67. Dextroamphetamine/amphetamine ER Caps / ESRD _____ _____
Alert Message: Mydayis (dextroamphetamine/amphetamine) is not recommended for use in patients with end stage renal disease (ESRD < 15 ml/min/1.73m2).

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Dextroamphetamine/amphetamine ER caps		ESRD

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Mydayis Prescribing Information, June 2017, Shire US, Inc.

68. Dextroamphetamine/amphetamine ER Caps / Overutilization _____ _____
Alert Message: The manufacturer's recommended maximum total daily dose of Mydayis (dextroamphetamine/amphetamine), in pediatric patients 13 to 17 years of age, is 25 mg.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negate)**
Dextroamphetamine/amphetamine ER caps		CKD Stage 4 & 5

Max Dose: 25 mg/day
Age Range: 13 - 17 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Mydayis Prescribing Information, June 2017, Shire US, Inc.

69. Dextroamphetamine/amphetamine ER Caps / Severe Renal Impairment _____ _____

Alert Message: The manufacturer's recommended maximum total daily dose of Mydayis (dextroamphetamine/amphetamine), in pediatric patients 13 to 17 years of age with severe renal impairment (GFR 15 to < 30 ml/min/1.73m2), is 12.5mg. Dextroamphetamine/amphetamine extended-release is not recommended for use in patients with end stage renal disease (ESRD < 15 ml/min/1.73m2).

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Dextroamphetamine/amphetamine ER caps		CKD Stage 4 & 5

Max Dose: 12.5 mg/day
Age Range: 13 - 17 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Mydayis Prescribing Information, June 2017, Shire US, Inc.

70. Dextroamphetamine/amphetamine ER Caps / Severe Renal Impairment _____ _____

Alert Message: The safety and effectiveness of Mydayis (dextroamphetamine/amphetamine) have not been established in pediatric patients 12 years of age and younger.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Dextroamphetamine/amphetamine ER caps		

Age Range: 0 -12 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Mydayis Prescribing Information, June 2017, Shire US, Inc.

71. AirDuo Respiclick / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of AirDuo Respiclick (fluticasone) in pediatric patients below the age of 12 years have not been established.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Fluticasone Inhalation Powder		

References:
AirDuo Prescribing Information, Jan. 2017, Teva Respiratory, LLC.
Clinical Pharmacology, 2017 Elsevier Gold Standard.

- Prior authorization for a non-preferred agent with a preferred brand/generic equivalent in any category will be given only if DAW criteria is met in addition to clinical criteria and step therapy specific to that category.

- Prior authorization criteria applies in addition to the general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc. Refer to http://www.hidesigns.com/ndmedicaid for applicable quantity limits and therapeutic duplication edits.

- Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC drugs are not covered unless specified.

- The use of pharmaceutical samples will not be considered when evaluating the member's medical condition or prior prescription history for drugs that require prior authorization.

- This is NOT an all-inclusive list of medications covered by ND Medicaid. Please use the NDC Drug Lookup tool at http://nddruglookup.hidinc.com/ to view coverage status, quantity limits, copay, and prior authorization information for all medications.

- This is NOT an all-inclusive list of medications that require prior authorization. Please visit http://www.hidesigns.com/ndmedicaid/pa-criteria.html for PA criteria for medications not found on the PDL.

- This PDL is subject to change. Preferred positions and criteria will go into effect when an SRA is executed.

- Acronyms
  PA – Indicates preferred agents that require clinical prior authorization.
  *** - Indicates that additional PA criteria applies as indicated in the sidebar

This is NOT an all-inclusive list of covered medications or medications that require prior authorization. Only PDL managed categories are included. Refer to cover page for complete list of rules governing this PDL.

Visit http://www.hidesigns.com/ndmedicaid **for more information on medications not found in this list.**

CHANGES SINCE LAST VERSION		
Category	**Product Status Changes**	**Criteria Changes**
ADHD AGENTS	Dextroamphetamine 5 mg/5 ml moved to non-preferred	
ALLERGENIC EXTRACTS		removed as a PDL category
ANALGESICS - NSAIDS - TOPICAL		New PDL Category
TESTOSTERONE TOPICAL	ANDRODERM (testosterone) moved to preferred	Category name changed to ANDROGENS
ANTIHEMOPHILIC FACTORS		removed as a PDL category
COPD - Long Acting Anticholinergics		Spiriva Respimat criteria added
COPD		Category PA Criteria changes
COPD -Combination Anticholinergics/Long Acting Beta Agonists	BEVESPI AEROSPHERE (glycopyrrolate/formoterol) moved to preferred	
COPD -Combination Anticholinergics/Long Acting Beta Agonists	COMBIVENT RESPIMAT (albuterol/ipratropium) moved to non-preferred	Short and Long acting agents combined into one group. Group PA criteria updated
COPD -Combination Anticholinergics/Long Acting Beta Agonists	STIOLTO RESPIMAT (tiotropium/olodaterol moved to non-preferred	
CYSTIC FIBROSIS ANTIINFECTIVES		Category name changed to CYSTIC FIBROSIS INHALED ANTIBIOTICS
DIABETES - DPP4 INHIBITORS		ONGLYZA (saxagliptan) criteria removed
DIABETES - GLP1 AGONISTS	TANZEUM (albiglutide) moved to non-preferred	
DIABETES - GLP1 AGONISTS		Victoza Criteria removed, Category PA Criteria Updated
DIABETES - INSULIN		Category added to PDL
DIABETES - INSULIN		Individual insulin criteria updated
DIABETES - INSULIN/GLP1 AGONISTS		New PDL Category

This is NOT an all-inclusive list of covered medications or medications that require prior authorization. Only PDL managed categories are included. Refer to cover page for complete list of rules governing this PDL.

Visit http://www.hidesigns.com/ndmedicaid for more information on medications not found in this list.

CHANGES SINCE LAST VERSION		
Category	**Product Status Changes**	**Criteria Changes**
DIABETES - SGLT2 INHIBITORS	INVOKAMET XR (canagliflozin/metformin) moved to non-preferred	
DIABETES - SGLT2 INHIBITORS	SYNJARDY XR (empagliflozin/metformin) moved to preferred	
DIARRHEA - IRRITABLE BOWEL SYNDROME	LOTRONEX (alosetron) moved to preferred	
FIBROMYALGIA		removed as a PDL category
GOUT - COLCHICINE		removed as a PDL category
HEMATOPOIETIC, COLONY STIMULATING FACTORS		New PDL Category
HEMATOPOIETIC, GROWTH FACTOR		Category name changed to HEMATOPOIETIC, ERYTHROPOIESIS STIMULATING AGENTS
LICE	permethrin liquid removed from preferred	
MULTIPLE SCLEROSIS	REBIF (interferon beta-1A) moved to non-preferred	
MULTIPLE SCLEROSIS	REBIF REBIDOSE (interferon beta-1A) moved to non-preferred	
GLAUCOMA - SYMPATHOMIMETICS		Category name changed to OPHTHALMIC ALPHA ADRENERGICS - GLAUCOMA
OPHTHALMIC ANTIHISTAMINES	EMADINE (emedastine) moved to non-preferred	
OPHTHALMIC ANTIHISTAMINES	Epinastine moved to preferred	
OPHTHALMIC ANTIHISTAMINES	PATADAY 0.2% (olopatadine) moved to preferred	
OPHTHALMIC ANTIINFECTIVES	Bacitracin ointment moved to non-preferred	

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CHANGES SINCE LAST VERSION		
Category	**Product Status Changes**	**Criteria Changes**
OPHTHALMIC ANTIINFECTIVES	Sulfacetamide ointment moved to non-preferred	
OPHTHALMIC ANTIINFECTIVES	VIGAMOX (moxifloxacin) DROPS moved to non-preferred	
OPHTHALMIC ANTIINFECTIVES/ANTIINFLAMMATORIES	BLEPHAMIDE (sulfacetamide/prednisolone) DROPS moved to preferred	
OPHTHALMIC ANTIINFECTIVES/ANTIINFLAMMATORIES	MAXITROL (neomycin/polymyxin b/dexamethasone) DROPS moved to non-preferred	
OPHTHALMIC ANTIINFLAMMATORIES	Bromfenac sodium & BROMSITE (bromfenac sodium) moved to non-preferred	
OPHTHALMIC ANTIINFLAMMATORIES	DUREZOL (difluprednate) moved to non-preferred	
OPHTHALMIC ANTIINFLAMMATORIES	ketorolac tromethamine 0.4% moved to preferred	
OPHTHALMIC ANTIINFLAMMATORIES	Ketorolac tromethamine 0.5% moved to preferred	
OPHTHALMIC ANTIINFLAMMATORIES	LOTEMAX (loteprednol) DROPS moved to preferred	
OPHTHALMIC ANTIINFLAMMATORIES	LOTEMAX (loteprednol) OINTMENT moved to non-preferred	
OPHTHALMIC ANTIINFLAMMATORIES	NEVANAC (nepafenac) moved to non-preferred	
OPHTHALMIC ANTIINFLAMMATORIES	Prednisolone acetate 1% moved to non-preferred	
OPHTHALMIC ANTIINFLAMMATORIES	Prednisolone sodium phosphate 1% moved to preferred	
OPHTHALMIC ANTIINFLAMMATORIES	PROLENSA (bromfenac) moved to non-preferred	

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CHANGES SINCE LAST VERSION		
Category	**Product Status Changes**	**Criteria Changes**
OPHTHALMIC IMMUNOMODULATORS - DRY EYE SYNDROME		New PDL Category
OPIOID ANALGESIC - LONG ACTING	Tramadol ER moved to non-preferred	Category and PA criteria updated
OTIC ANTI-INFECTIVES - FLUOROQUINOLONES	ofloxacin drops - labeler 24208 moved to preferred	Category PA criteria updated
OTIC ANTI-INFECTIVES - FLUOROQUINOLONES	OTOVEL (ciprofloxacin/fluocinolone) moved to preferred	
PHOSPHATE BINDERS	ELIPHOS (calcium acetate) moved to non-preferred	Velphoro criteria removed
PLATELET AGGREGATION INHIBITORS	AGGRENOX (aspirin/dipyridamole) moved to preferred	
PLATELET AGGREGATION INHIBITORS	Aspirin/dipyridamole ER moved to non-preferred	
PLATELET AGGREGATION INHIBITORS	EFFIENT (prasugrel) moved to non-preferred	
PLATELET AGGREGATION INHIBITORS	Prasugrel added to non-preferred	
PULMONARY HYPERTENSION-Prostacyclins	REMODULIN (treprostinil) moved to preferred	
PULMONARY HYPERTENSION-Soluble Guanylate Cyclase Stimulators		Criteria Changes
STEROID/LONG ACTING BETA AGONIST (LABA) COMBINATION INHALERS		AIRDUO RESPICLICK (fluticasone/salmeterol) criteria added
STEROID/LONG ACTING BETA AGONIST (LABA) COMBINATION INHALERS		Category Criteria updated
STEROID INHALERS	AEROSPAN (flunisolide) moved to non-preferred	Category name changed to STEROIDs - INHALED
STEROID INHALERS	budesonide suspension 0.25 mg/2mL added to preferred	
STEROID INHALERS	budesonide suspension 0.5 mg/2mL added to preferred	

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CHANGES SINCE LAST VERSION		
Category	**Product Status Changes**	**Criteria Changes**
STEROID INHALERS	FLOVENT DISKUS (fluticasone) moved to non-preferred	
STEROID INHALERS	PULMICORT RESPULES (budesonide) 1 mg/2 mL added to preferred	
INFLAMMATORY BOWEL AGENTS (ULCERATIVE COLITIS) - NONSTEROIDAL		Category name changed to ULCERATIVE COLITIS AGENTS - NONSTEROIDAL
URINARY ANTISPASMODICS		Myrbetriq criteria updated

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ADHD AGENTS		
Category PA Criteria: Branded non-preferred agents: A 10-day trial of 2 pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. Generic non-preferred agents: A 10-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. Rational of inability to swallow a solid dosage form must be provided after age 9 for all non-solid dosage forms.		
ADDERALL XR (dextroamphetamine/amphetamine)	ADDERALL (dextroamphetamine/amphetamine)	*** Kapvay will require a 1-month trial of immediate release clonidine.
ADZENYS XR - ODT (amphetamine)	Clonidine ER	
APTENSIO XR (methylphenidate)	CONCERTA (methylphenidate)	
Atomoxetine	DEXEDRINE (dextroamphetamine)	
Clonidine	Dexmethylphenidate ER	
COTEMPLA XR - ODT (methylphenidate)	Dextroamphetamine 5 mg/5 ml	
DAYTRANA (methylphenidate)	Dextroamphetamine/amphetamine ER - Labelers 00115, 00228, 00555, 66993	
DESOXYN (methamphetamine)	FOCALIN (dexmethylphenidate)	
Dexmethylphenidate	INTUNIV (guanfacine ER)	
Dextroamphetamine	METADATE ER (methylphenidate)	
Dextroamphetamine ER	METHYLIN (methylphenidate) chew tablets	
Dextroamphetamine/amphetamine	METHYLIN (methylphenidate) solution	
Dextroamphetamine/amphetamine ER - Labeler 00781	RITALIN (methylphenidate)	
DYANAVEL XR (amphetamine)	RITALIN LA (methylphenidate LA capsules - 50-50)	
EVEKEO (amphetamine)	STRATTERA (atomoxetine)	
FOCALIN XR (dexmethylphenidate)	ZENZEDI (dextroamphetamine)	
Guanfacine ER		
KAPVAY (clonidine)[PA***]		
Methamphetamine		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Methylphenidate CD 30-70		
Methylphenidate chew tablet		
Methylphenidate ER capsules 50-50		
Methylphenidate ER tablet		
Methylphenidate LA capsules - 50-50		
Methylphenidate solution		
Methylphenidate tablet		
MYDAYIS (amphetamine/dextroamphetamine)		
PROCENTRA (dextroamphetamine)		
QUILLICHEW ER (methylphenidate)		
QUILLIVANT XR (methylphenidate)		
VYVANSE (lisdexamfetamine)		
VYVANSE (lisdexamfetamine) CHEW TABLET		
ANGINA		
RANEXA (ranolazine)		
ANALGESICS - NSAIDS - TOPICAL		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. A medical reason must be provided why preferred agents do not work.		
FLECTOR (diclofenac) PATCH	DERMACINRX LEXITRAL (diclofenac/capsicum)	
PENNSAID (diclofenac)	XRYLIX (diclofenac)	
VOLTAREN (diclofenac) GEL	VOPAC MDS (diclofenac)	
ANDROGENS		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. All medications require an FDA-approved indication.		
ANDROGEL (testosterone) PACKET 1%PA	AXIRON (testosterone) TOPICAL SOLUTION	
ANDROGEL (testosterone) PACKET 1.62%PA	FORTESTA (testosterone)	
ANDRODERM (testosterone)	NATESTO (testosterone)	
	TESTIM (testosterone)	
	TESTOPEL (testosterone)	
	Testosterone gel	
	Testosterone Gel MD PMP	
	Testosterone topical solution	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	VOGELXO (testosterone) GEL MD PMP	
ANTICOAGULANTS - ORAL		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. All agents will require an FDA indication.		
ELIQUIS (Apixaban)PA	SAVAYSA (edoxaban)	
PRADAXA (dabigatran)PA		
XARELTO (rivaroxaban)PA		
ANTICONVULSANTS		
Category PA Criteria: Branded non-preferred agents: A 30-day trial of 2 pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. Generic non-preferred agents: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
APTIOM (eslicarbazepine)	CARBATROL (carbamazepine)	
BANZEL (rufinamide) ORAL SUSPENSION	DEPAKENE (valproic acid) CAPSULE	
BANZEL (rufinamide) TABLET	DEPAKENE (valproic acid) ORAL SOLUTION	
BRIVIACT (brivaracetam)	DEPAKOTE (divalproex sodium) TABLET	
Carbamazepine chewable tablet	DEPAKOTE ER (divalproex sodium)	
Carbamazepine ER capsule	DEPAKOTE SPRINKLE (divalproex sodium)	
Carbamazepine oral suspension	DILANTIN (phenytoin) CHEWABLE TABLET	
Carbamazepine tablet	DILANTIN (phenytoin) ORAL SUSPENSION	
Carbamazepine XR tablet	DILANTIN ER (phenytoin)	
CELONTIN (methsuximide)	EPITOL (carbamazepine)	
Divalproex ER	FELBATOL (felbamate)	
Divalproex sprinkle	FELBATOL (felbamate) ORAL SUSPENSION	
Divalproex tablet	KEPPRA (levetiracetam)	
Ethosuximide capsule	KEPPRA (levetiracetam) ORAL SOLUTION	
Ethosuximide oral solution	KEPPRA XR (levetiracetam)	
Felbamate oral suspension	LAMICTAL (lamotrigine)	
Felbamate tablet	LAMICTAL (lamotrigine) CHEWABLE TABLET	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
FYCOMPA (perampanel)	LAMICTAL (lamotrigine) DOSE PACK	
FYCOMPA (perampanel) ORAL SUSPENSION	MYSOLINE (primidone)	
Gabapentin capsule	NEURONTIN (gabapentin) CAPSULE	
Gabapentin oral solution	NEURONTIN (gabapentin) ORAL SOLUTION	
Gabapentin tablet	NEURONTIN (gabapentin) TABLET	
GABITRIL (tiagabine)	QUDEXY XR (topiramate)	
LAMICTAL ER (lamotrigine) DOSE PACK	TEGRETOL XR (carbamazepine)	
LAMICTAL ODT (lamotrigine)	TEGRETROL (carbamazepine oral suspension)	
LAMICTAL ODT (lamotrigine) DOSE PACK	TOPAMAX (topiramate)	
LAMICTAL XR (lamotrigine)	TOPAMAX (topiramate) SPRINKLE CAPSULE	
Lamotrigine chewable tablet	TRILEPTAL (oxcarbazepine)	
Lamotrigine dose pack	TRILEPTAL (oxcarbazepine) ORAL SUSPENSION	
Lamotrigine ER	ZARONTIN (ethosuximide)	
Lamotrigine ODT	ZARONTIN (ethosuximide) ORAL SOLUTION	
Lamotrigine tablet	ZONEGRAN (zonisamide)	
Levetiracetam ER		
Levetiracetam oral solution		
Levetiracetam tablet		
LYRICA (pregabalin)		
LYRICA (pregabalin) ORAL SOLUTION		
Oxcarbazepine oral solution		
Oxcarbazepine tablet		
OXTELLAR XR (oxcarbazepine)		
PEGANONE (Ethotoin)		
Phenobarbital elixir		
Phenobarbital tablet		
PHENYTEK (phenytoin)		
Phenytoin chewable tablet		
Phenytoin ER capsule		
Phenytoin suspension		
POTIGA (ezogabine)		
Primidone		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
SABRIL (vigabatrin)		
SABRIL (vigabatrin) POWDER PACK		
SPRITAM (levetiracetam)		
TEGRETOL (carbamazepine)		
Tiagabine		
Topiramate ER		
Topiramate sprinkle capsule		
Topiramate tablet		
TROKENDI XR (topiramate)		
Valproic acid capsule		
Valproic acid oral solution		
VIMPAT (lacosamide)		
VIMPAT (lacosamide) ORAL SOLUTION		
Zonisamide		
ANTIDEMENTIA		
Category PA Criteria: All agents will require an FDA indication for patients younger than 30 years old. Branded non-preferred agents: A 30-day trial of 2 pharmaceutically preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. A 30-day trial of 2 preferred generics of the same medication will satisfy this requirement. Generic non-preferred agents: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
Donepezil	ARICEPT (donepezil)	***Namenda XR – A 30-day trial of memantine IR will be required before Namenda XR will be authorized.
EXELON (rivastigmine)	Donepezil ODT	
EXELON (rivastigmine) PATCH	NAMENDA (memantine)	
Galantamine	NAMZARIC (memantine/donepezil)	
Galantamine ER	RAZADYNE (galantamine)	
Galantamine oral solution	RAZADYNE ER (galantamine)	
Memantine	Rivastigmine patch	
NAMENDA (memantine) ORAL SOLUTION		
NAMENDA XR (memantine)***		
Rivastigmine		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIDEPRESSANTS - NEW GENERATION		
Category PA Criteria: Branded non-preferred agents: A 30-day trial of 2 pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. Generic non-preferred agents: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
Bupropion SR tablet	APLENZIN ER (bupropion)	
Bupropion tablet	CELEXA (citalopram)	
Bupropion XL tablet	CYMBALTA (duloxetine)	
Citalopram	Desvenlafaxine ER	
Citalopram oral solution	Desvenlafaxine fumarate ER	
Clomipramine	Desvenlafaxine succinate ER - labelers 00591, 51991, 68180	
Desvenlafaxine succinate ER - labeler 59762	EFFEXOR XR (venlafaxine)	
Duloxetine	FORFIVO XL (bupropion)	
Escitalopram	IRENKA (duloxetine)	
Escitalopram oral solution	KHEDEZLA ER (desvenlafaxine)	
FETZIMA (levomilnacipran)	LEXAPRO (escitalopram)	
Fluoxetine capsule	LEXAPRO (escitalopram) ORAL SOLUTION	
Fluoxetine DR	PAXIL (paroxetine)	
Fluoxetine solution	PAXIL CR (paroxetine)	
Fluoxetine tablet	PRISTIQ ER (desvenlafaxine)	
Fluvoxamine	PROZAC (fluoxetine)	
Fluvoxamine ER	venlafaxine ER tablets	
Nefazodone	WELLBUTRIN (bupropion)	
OLEPTRO ER (trazodone)	WELLBUTRIN SR (bupropion)	
Paroxetine	WELLBUTRIN XL (bupropion)	
Paroxetine ER	ZOLOFT (sertraline)	
PAXIL (paroxetine) ORAL SUSPENSION	ZOLOFT (sertraline) ORAL CONCENTRATE	
PEXEVA (paroxetine)		
Sertraline		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Sertraline oral concentrate		
Trazodone		
TRINTELLIX (vortioxetine)		
Venlafaxine ER capsules		
Venlafaxine tablet		
VIIBRYD (vilazodone)		
ANTIRETROVIRALS - NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS		
Abacavir	EPIVIR (lamivudine)	
Abacavir/lamivudine	EPZICOM (abacavir)	
Abacavir/lamivudine/zidovudine	TRIZIVIR (abacavir/lamivudine)	
ATRIPLA (efavirenz/emtricitabine/tenofovir)	VIDEX EC (didanosine)	
COMBIVIR (lamivudine/zidovudine)	VIREAD (tenofovir)	
COMPLERA (emtricitabine/rilpivirine/tenofovir)	ZERIT (stavudine)	
DESCOVY (emtricitabine/tenofovir)	ZIAGEN (abacavir)	
Didanosine		
EMTRIVA (emtricitabine)		
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)		
Lamivudine		
Lamivudine/zidovudine		
ODEFSEY (emtricitabine/rilpivirine/tenofovir)		
RETROVIR (zidovudine)		
Stavudine		
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)		
Tenofovir		
TRIUMEQ (abacavir/dolutegravir/lamivudine)		
TRUVADA (emtricitabine/tenofovir)		
VIDEX (didanosine)		
Zidovudine		
ANTIRETROVIRALS - PROTEASE INHIBITORS		
APTIVUS (tipranavir)	KALETRA (lopinavir/ritonavir)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CRIXIVAN (indinavir)		
EVOTAZ (atazanavir/cobicistat)		
GENVOYA (elvitegravir, cobicistat, emtricitabine and tenofovir)		
INVERASE (saquinavir)		
LEXIVA (fosamprenavir)		
lopinavir/ritonavir		
NORVIR (ritonavir)		
PREZCOBIX (darunavir/cobicistat)		
PREZISTA (darunavir)		
RAYATAZ (atazanavir)		
VIRACEPT (nelfinavir)		
ATYPICAL ANTIPSYCHOTICS		
Category PA Criteria: Branded non-preferred agents: A 30-day trial of 2 pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. Generic non-preferred agents: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
ABILIFY (aripiprazole) ORAL SOLUTION	ABILIFY (aripiprazole)	
ABILIFY DISCMELT (aripiprazole)	CLOZARIL (clozapine)	
Aripiprazole	GEODON (ziprasidone)	
Clozapine	INVEGA ER (paliperidone)	
Clozapine ODT	quetiapine ER - labelers 00406, 16729, 49884, 52817	
FANAPT (iloperidone)	RISPERDAL (risperidone)	
FAZACLO (clozapine) RAPDIS	RISPERDAL (risperidone) ORAL SOLUTION	
LATUDA (lurasidone)	RISPERDAL M-TAB (risperidone)	
Olanzapine	SEROQUEL (quetiapine)	
Olanzapine ODT	SEROQUEL XR (quetiapine)	
Olanzapine/fluoxetine	ZYPREXA (olanzapine)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Paliperidone ER	ZYPREXA ZYDIS (olanzapine)	
Quetiapine		
quetiapine ER - labeler 00310		
REXULTI (brexpiprazole)		
Risperidone		
Risperidone ODT		
Risperidone oral solution		
SAPHRIS (asenapine)		
SEROQUEL XR (quetiapine) 400mg		
SYMBYAX (olanzapine/fluoxetine)		
VRAYLAR (cariprazine)		
Ziprasidone		
ATYPICAL ANTIPSYCHOTICS - LONG ACTING		
ABILIFY MAINTENA (aripiprazole)		
ARISTADA (aripiprazole lauroxil)		
INVEGA SUSTENNA (paliperidone)		
INVEGA TRINZA (paliperidone)		
RISPERDAL CONSTA (risperidone)		
ZYPREXA RELPREVV (olanzapine)		
CONSTIPATION - IRRITABLE BOWEL SYNDROME/OPIOID INDUCED		
Category PA Criteria: Patients must be 18 years old. All medications will require an FDA indication. For opioid-induced constipation, a paid claim for an opioid must be on patient's profile and a 30 day trial of Amitiza will be required before a non-preferred oral agent will be authorized. For idiopathic constipation, a 30 day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
AMITIZA (lubiprostone)	MOVANTIK (naloxegol)	***Linzess – A 30-day trial of Amitiza is required before Linzess will be authorized. ***Relistor Syringe/Vial – Documentation must be submitted to show inability to swallow a solid dosage form
LINZESS (linaclotide)PA***	RELISTOR (methylnaltrexone) SYRINGE***	
	RELISTOR (methylnaltrexone) TABLET***	
	RELISTOR (methylnaltrexone) VIAL***	
	SYMPROIC (naldemedine)	
	TRULANCE (plecanatide)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		***Relistor tablets - A 30 day trial of Movantik is required before Relistor tablets will be authorized
COPD		
Category PA Criteria: All preferred agents indicated only for COPD will require verification of FDA-approved indication for patients who are younger than 40 years of age. All non-preferred agents will require an FDA-approved indication regardless of age.		
Long Acting Anticholinergics		
Group PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
SPIRIVA (tiotropium)	INCRUSE ELLIPTA (umeclidinium)	***SPIRIVA RESPIMAT 2.5 MG (tiotropium) will require a 30 day trial of Incruse Ellipta and Tudorza Pressair in addition to Category PA Criteria
	SPIRIVA RESPIMAT 2.5 MG (tiotropium)***	
	TUDORZA PRESSAIR (aclidinium)	
Long Acting Beta Agonists		
PERFOROMIST (formoterol)	ARCAPTA NEOHALER (indacaterol)***	***Arcapta Neohaler/Striverdi Respimat will require a 30 day trial of Serevent in addition to Category PA Criteria ***Brovana will require a 30 day trial of Perforomist in addition to Category PA Criteria
SEREVENT (salmeterol)	BROVANA (arformoterol)***	
	STRIVERDI RESPIMAT (olodaterol)***	
Combination Anticholinergics/Long Acting Beta Agonists		
Group PA Criteria: All preferred agents indicated only for COPD will require verification of FDA-approved indication for patients who are younger than 40 years of age. A 30-day trial of 2 long acting preferred products will be required before a non-preferred agent (short or long acting) will be authorized.		
Albuterol/ipratropium	COMBIVENT RESPIMAT (albuterol/ipratropium)	
ANORO ELLIPTA (umeclidinium/vilanterol)	DUONEB (albuterol/ipratropium)	
BEVESPI AEROSPHERE (glycopyrrolate/formoterol)	STIOLTO RESPIMAT (tiotropium/olodaterol)	
	UTIBRON NEOHALER (glycopyrrolate/indacaterol)	
Combination Steroid/Anticholinergics/Long Acting Beta Agonists		
Group PA Criteria: In addition to the category PA criteria, patient must a 30 day trial of all preferred agents in the following combinations: 1. Steroid/Long Acting Beta Agonist (LABA) Combination Inhalers + Long Acting Anticholinergics 2. Combination Anticholinergics/Long Acting Beta Agonist + Inhaled Steriod		
	TRELEGY ELLIPTA (Fluticasone Furoate/Umeclidinium/Vilanterol)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
PDE4 - Inhibitor		
Group PA Criteria: In addition to the category PA criteria, patient must have a history of exacerbations treated with corticosteroids within the last year for initial requests and must have had a decreased number of exacerbations treated with corticosteroids with Daliresp treatment with renewals. Patient must also have had a 30 day trial with a medication in each of the following therapeutic classes from either single ingredient or combination products: 1. Long acting anticholinergic 2. Long acting beta agonist 3. Inhaled Steroid		
	DALIRESP (roflumilast)	
CYSTIC FIBROSIS INHALED ANTIBIOTICS		
Category PA Criteria: A 28-day trial of 1 preferred agent will be required before a non-preferred agent will be authorized. Non-preferred agents will require that the patient not have been colonized with Burkholderia cepacia and an FDA-approved age and indication.		
BETHKIS (tobramycin)	CAYSTON (aztreonam)***	***Cayston – Patient must have a forced expiratory volume in less than 1 second (FEV1) of less than 25% or greater than 75% predicted. ***Tobramycin/TOBI Podhaler – Patient must have a forced expiratory volume in less than 1 second (FEV1) of less than 40% or greater than 80% predicted. Patient must not have been colonized with *Burkholderia cepacia.*
KITABIS PAK (tobramycin/nebulizer)	TOBI PODHALER (Tobramycin)***	
	Tobramycin***	
	TOBI (Tobramycin)***	
CYTOKINE MODULATORS		
Category PA Criteria: A 3-month trial of 2 preferred agents will be required before a non-preferred agent will be authorized. All agents will require an FDA-approved indication.		
COSENTYX (secukinumab)[PA]	ACTEMRA (tocilizumab)	
ENBREL (etanercept)[PA]	CIMZIA (certolizumab)	
HUMIRA (adalimumab)[PA]	KEVZARA (sarilumab)	
HUMIRA PSORIASIS (adalimumab)[PA]	KINERET (anakinra)	
	ORENCIA (abatacept)	
	OTEZLA (apremilast)	
	SILIQ (brodalumab)	
	SIMPONI (golimumab)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	STELARA (ustekinumab)	
	TALTZ (ixekizumab)	
	TREMFYA (guselkumab)	
	XELJANZ (tofacitinib)	
	XELJANZ XR (tofacitinib)	
DIABETES - DPP4 INHIBITORS		
Category PA Criteria: Non preferred agents will require: 1. A 30-day trial of 1 sitagliptin preferred product (Janumet, Janumet XR, or Januvia) and 1 linagliptin preferred product (Jentadueto or Tradjenta). 2. An FDA approved indication. 3. Concurrent metformin therapy. 4. A 3-month trial of metformin		
JANUMET (sitagliptin/metformin)	alogliptan/pioglitzone	***Onglyza - will require an FDA indication, a 3 month trial of metformin and concurrent metformin therapy
JANUMET XR (sitagliptin/metformin)	alogliptin/metformin	
JANUVIA (sitagliptin)	JENTADUETO XR (linagliptin/metformin)	
JENTADUETO (linagliptin/metformin)	KAZANO (alogliptin/metformin)	
KOMBIGLYZE XR (saxagliptin/metformin)	NESINA (alogliptin)	
ONGLYZA (saxagliptin)PA***	OSENI (alogliptin/pioglitazone)	
TRADJENTA (linagliptin)	alogliptin	
DIABETES - GLP1 AGONISTS		
Category PA Criteria: Preferred agents will require: 1. A 3-month trial of metformin. Non preferred agents will require: 1. A 30-day trial of 2 preferred agents. 2. An FDA indication. 3. Concurrent metformin therapy. 4. A 3-month trial of metformin		
BYDUREON (exenatide microspheres)	ADLYXIN (lixisenatide)	
BYETTA (exenatide)	TRULICITY (dulaglutide)	
VICTOZA (liraglutide)	TANZEUM (albiglutide)	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
DIABETES - INSULIN/GLP1 AGONISTS		
Category PA Criteria: 1. A 30-day trial of exenatide and liraglutide GLP-1 agonists in combination with each of insulin glargine and insulin detemir insulins 2. An FDA indication. 3. Concurrent metformin therapy. 4. A 3-month trial of metformin		
	SOLIQUA (Insulin glargine/lixisenatide)	
	XULTOPHY (insulin degludec/liraglutide)	
DIABETES - INSULIN		
Syringe/Pens: • Prescriber must provide a reason why patient needs to use a syringe/pen instead of a vial, subject to clinical review **Vials of non-preferred insulin:** • Patient must have failed a 30 day trial of a preferred insulin: Humalog, Humalox Mix 50/50, Humalog Mix 75/25, Humulin 70/30, Humulin N, Humulin R, Humulin R U-500, Lantus, Levemir, Novolin R, Novolog, or Novolog Mix 70/30, as evidenced by paid claims or pharmacy print outs.		
APIDRA (insulin glulisine) VIAL	AFREZZA (insulin regular, human)	***Fiasp •Patient must have had 30 day trial with Novolog, Humalog, and Apidra ***Tresiba U-1 00 & Basaglar: •Patient must fail a 3 month trial of both Lantus and Levemir with good compliance, as evidenced by paid claims or pharmacy print outs. ***Toujeo/Tresiba U-200: •Patient must require a minimum of 100 units/day of Lantus or Levemir for a minimum of 3 months with good compliance, as evidenced by paid claims or pharmacy print outs.
APIDRA SOLOSTAR (insulin glulisine) INSULIN PEN	BASAGLAR KWIKPEN U-100 (insulin glargine)***	
HUMALOG (insulin lispro) VIAL	FIASP (insulin aspart) FLEXTOUCH***	
HUMALOG MIX 50/50 (insulin NPL/insulin lispro) VIAL	FIASP (insulin aspart) VIAL***	
HUMALOG MIX 75/25 (insulin NPL/insulin lispro) VIAL	HUMALOG (insulin lispro) CARTRIDGE	
HUMULIN 70/30 (insulin NPH human/regular insulin human) VIAL	HUMALOG (insulin lispro) KWIKPEN	
HUMULIN N (insulin NPH human isophane) VIAL	HUMALOG JUNIOR KWIKPEN (insulin lispro)	
HUMULIN R (insulin regular, human) VIAL	HUMALOG MIX 50/50 (insulin NPL/insulin lispro) KWIKPEN	
HUMULIN R U-500 (insulin regular, human) VIAL	HUMALOG MIX 75/25 (insulin NPL/insulin lispro) KWIKPEN	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
LANTUS (insulin glargine) SOLOSTAR	HUMULIN 70/30 (insulin NPH human/regular insulin human) KWIKPEN	
LANTUS (insulin glargine) VIAL	HUMULIN N (insulin NPH human isophane) KWIKPEN	
LEVEMIR (insulin detemir) VIAL	HUMULIN R (Insulin regular, human) U-500 KWIKPEN	
LEVEMIR (insulin detemir) FLEXTOUCH	NOVOLIN 70-30 (insulin NPH human/regular insulin human) VIAL	
NOVOLIN R (insulin regular, human) VIAL	NOVOLIN N (insulin NPH human isophane) VIAL	
NOVOLOG (insulin aspart) CARTRIDGE	TOUJEO SOLOSTAR (insulin glargine)***	
NOVOLOG (insulin aspart) FLEXPEN	TRESIBA (insulin degludec) FLEXTOUCH U-100***	
NOVOLOG (insulin aspart) VIAL	TRESIBA (insulin degludec) FLEXTOUCH U-200***	
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) FLEXPEN		
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) VIAL		
DIABETES - SGLT2 INHIBITORS		
Category PA Criteria: Non-preferred agents will require: 1. An FDA indication. 2. A 3-month trial of a metformin 3. A 3-month trial of a canagliflozin and a 3-month trial of a empagliflozin agent. 4. Concurrent metformin therapy – this condition will be considered met if requested product is a metformin combination agent.		
INVOKAMET (canagliflozin)	FARXIGA (dapagliflozin)	
INVOKANA (canagliflozin)	GLYXAMBI (empagliflozin/linagliptin)	
JARDIANCE (empagliflozin)	INVOKAMET XR (canagliflozin/metformin)	
SYNJARDY (empagliflozin/metformin)	XIGDUO XR (dapagliflozin/metformin)	
SYNJARDY XR (empagliflozin/metformin)		
DIARRHEA - IRRITABLE BOWEL SYNDROME		
Category PA Criteria: Patient must be 18 years of age or older. A 30-day trial of all preferred agents will be required before a non-preferred medication will be approved.		
loperimide	alosetron***	***Alosetron– Patient must be a female.
LOTRONEX (alosetron)***		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
VIBERZI (eluxadoline)		
XIFAXIN (rifaximin) 550 mg tablet		
DIGESTIVE ENZYMES		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
CREON (lipase/protease/amylase)	PANCREAZE (lipase/protease/amylase)	
ZENPEP (lipase/protease/amylase)	PANCRELIPASE (lipase/protease/amylase)	
	PERTZYE (lipase/protease/amylase)	
	ULTRESA (lipase/protease/amylase)	
	VIOKACE (lipase/protease/amylase)	
EPINEPHRINE AUTOINJECTORS		
Category PA Criteria: Medical justification must be provided for why the preferred product will not work.		
epinephrine - labeler 49502	ADRENACLICK (epinephrine)	
	epinephrine - labelers 00115, 54505	
	EPIPEN (epinephrine)	
	EPIPEN JR (epinephrine)	
GROWTH HORMONE		
Category PA Criteria: 1. Patients new to GH therapy must meet the criteria below and be started on a preferred growth hormone. 2. Patients continuing GH therapy and having met the criteria listed below must be switched to a preferred growth hormone. Additional criteria applies. For details, see http://hidesigns.com/assets/files/ndmedicaid/2017/Criteria/growth_hormone_criteria.pdf		
GENOTROPIN (somatropin)[PA]	HUMATROPE (somatropin)	
GENOTROPIN MINIQUICK (somatropin)[PA]	NUTROPIN AQ (somatropin)	
NORDITROPIN FLEXPRO (somatropin)[PA]	OMNITROPE (somatropin)	
	SAIZEN (somatropin)	
	ZOMACTON (somatropin)	
HEART FAILURE - NEPRILYSIN INHIBITOR/ANGIOTENSIN RECEPTOR BLOCKER		
Category PA Criteria: 1. Patient must have symptomatic chronic heart failure (NYHA class II-IV). 2. Patient must have systolic dysfunction (left ventricular ejection fraction ≤ 40%).		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ENTRESTO (sacubitril/valsartan)		
HEMATOPOIETIC, COLONY STIMULATING FACTORS		
GRANIX (TBO-Filgrastim)		
LEUKINE (Sargramostim)		
NEULASTA (Pegfilgrastim)		
NEUPOGEN (Filgrastim)		
ZARXIO (Filgrastim-SNDZ)		
HEMATOPOIETIC, ERYTHROPOIESIS STIMULATING AGENTS		
Category PA Criteria: All agents will require an FDA indication. A 4-week trial of all preferred products will be required before non-preferred agents will be authorized.		
ARANESP (darbepoetin alfa)[PA]	EPOGEN (epoetin alfa)	
PROCRIT (epoetin alfa)[PA]	MIRCERA (methoxy polyethylene glycol-epoetin beta)	
HEPATITIS C TREATMENTS		
Category PA Criteria: Non-preferred agents will require a failed trial of all preferred treatment options indicated for the patient's genotype and be labeled for failure of previous treatment. 1. Patient must have an FDA-approved diagnosis. 2. Patient must be an FDA-approved age. 3. Patient must attest that they will continue treatment without interruption for the duration of therapy. 4. Prescriber must be, or consult with, a hepatologist, gastroenterologist, or infectious disease specialist. 5. Prescriber must provide documentation that the patient has been drug and alcohol free for the past 12 months. Documentation includes at least 2 drug and alcohol tests dated at least 3 months apart and chart notes addressing patient's alcohol and drug free status throughout the past year. 6. HCV RNA level must be taken on week 4 and sent with a renewal request for any duration of treatment 12 weeks or longer. 7. Females using ribavirin must have a negative pregnancy test in the last 30 days and receive monthly pregnancy tests during treatment. 8. Patient must have established compliant behavior including attending scheduled provider visits (defined as 1 or less no-shows) and filling maintenance medications on time as shown in the prescription medication history for the past 12 months. 9. Patient must be tested for hepatitis B, and if the test is positive, hepatitis B must either be treated or closely monitored if patient does not need treatment. 10. Patient must not have life expectancy of less than 12 months due to non-liver related comorbid conditions. 11. PA approval duration will be based on label recommendation.		
EPCLUSA (sofosbuvir/velpatasvir)[PA***]	DAKLINZA (Daclatasvir)	***Epclusa: • Must be used with ribavirin for patients with decompensated cirrhosis (Child-Pugh B or Child-Pugh
MAVYRET (glecaprevir/pibrentasvir)[PA***]	HARVONI (ledipasvir/sofosbuvir)	
	OLYSIO (simeprevir)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	SOVALDI (sofosbuvir)	C). ***Mavyret/Vosevi: • Patient must not have decompensated cirrhosis (Child-Pugh B or Child-Pugh C)
	TECHNIVIE (ombitasvir/paritaprevir/ritonavir)	
	VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)	
	VIEKIRA PAK XR (dasabuvir/ombitasvir/paritaprevir/ritonavir)	
	VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)	
	ZEPATIER (elbasvir/grazoprevir)	
LICE		
Category PA Criteria: A 28-day/2-application trial of each of the preferred agents will be required before a non-preferred agent will be authorized. This requirement will be waived in the presence of a documented community breakout of a resistant strain that is only susceptible to a non-preferred agent.		
EURAX (crotamiton) CREAM	ELIMITE (permethrin) CREAM	
LICE SOLUTION (piperonyl butoxide/pyrethrins)	EURAX (crotamiton) LOTION	
NATROBA (spinosad)	Malathion	
Permethrin cream	OVIDE (malathion)	
SKLICE (ivermectin)	Spinosad	
ULESFIA (benzyl alcohol)		
MIGRAINE PROPHYLAXIS - 5HT(1) AGONISTS		
Category PA Criteria: Patients 18 years old or older: A 30-day trial of all preferred agents in the past 24 months will be required before a non-preferred agent will be authorized. Patients 6 to 17 years of age: A 30-day trial of rizatriptan in the past 24 months will be required before a non-preferred agent will be authorized.		
RELPAX (eletriptan)	Almotriptan	***Treximet – For patients 18 years or older, the patient must be stable on the combination product and have had a 30-day trial of naproxen in addition to sumatriptan to be approved. This criteria is in addition to the class criteria.
Rizatriptan	ALSUMA (sumatriptan) PEN INJCTR***	
Rizatriptan tab rap. dis.	AMERGE (naratriptan)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Sumatriptan tablet	Eletriptan	***Frovatriptan – A 30-day trial of naratriptan 2.5 mg within the past 24 months will be required in addition to the class criteria. The patient's migraine headaches must either menstrual, long in duration, and/or recurring. ***Almotriptan – A 30-day trial of Zolmitriptan 5 mg in the past 24 months will be required in addition to the class criteria. **Zembrance Symtouch/Sumatriptan Injection – A 30-day trial of Naratriptan 2.5 mg, Sumatriptan Nasal Spray 20 mg, Zomig Nasal Spray 5 mg, Zolmitriptan 5 mg, Axert 12.5 mg, Treximet, and Frova in the past 24 months will be required in addition to the class criteria.
	FROVA (frovatriptan)***	
	Frovatriptan	
	IMITREX (sumatriptan) CARTRIDGE***	
	IMITREX (sumatriptan) PEN INJCTR***	
	IMITREX (sumatriptan) SPRAY	
	IMITREX (sumatriptan) TABLET	
	IMITREX (sumatriptan) VIAL***	
	MAXALT (rizatriptan)	
	MAXALT MLT (rizatriptan)	
	Naratriptan	
	ONSETRA XSAIL (sumatriptan)***	
	Sumatriptan cartridge***	
	Sumatriptan pen injctr***	
	Sumatriptan spray	
	Sumatriptan syringe***	
	Sumatriptan vial***	
	SUMAVEL DOSEPRO (sumatriptan)	
	TREXIMET (sumatriptan/naproxen)***	
	Zolmitriptan	
	Zolmitriptan ODT	
	ZOMIG (zolmitriptan)	
	ZOMIG (zolmitriptan) SPRAY	
	ZOMIG ODT (zolmitriptan)	
MULTIPLE SCLEROSIS		
Interferons		
Category PA Criteria: A 3-month long trial of a preferred agent will be required before a non-preferred agent will be authorized. An FDA indication is required.		
AVONEX (interferon beta-1A) PEN	EXTAVIA (interferon beta-1B)	
AVONEX (interferon beta-1A) SYRINGE	PLEGRIDY (peginterferon beta-1A) PEN	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
AVONEX (interferon beta-1A) VIAL	PLEGRIDY (peginterferon beta-1A) SYRINGE	
BETASERON (interferon beta-1B)	REBIF (interferon beta-1A)	
	REBIF REBIDOSE (interferon beta-1A)	
Injectable Non-Interferons		
Category PA Criteria: A 3-month long trial of all preferred agents and 3-month trials of Aubagio, Tecfidera, and Gilenya will be required before a non-preferred agent will be authorized. If patient has a documented intolerance, hypersensitivity, or labeled contraindication to Copaxone, a 3-month trial of interferon beta-1 is required. An FDA indication is required. Prescriber must be a neurologist		
COPAXONE (glatiramer) 20 MG/ML	COPAXONE (glatiramer) 40 MG/ML***	***Zinbryta: • Transaminase and bilirubin levels must have been obtained within 6 months of request. • Patient must not have hepatitis B or C. • Patient must be screened for TB and have been treated if TB positive. • If patient has early aggressive disease defined as ≥ 2 relapses in the year and ≥ 1 Gadolinium (Gd)+ lesion, the trials of oral non-interferons will not be required. • Patient must have Anti-JC virus antibodies taken. ***Copaxone/Glatopa: • A reason must be indicated why Copaxone 20 mg/mL will not work.
	Glatopa (glatiramer)***	
	ZINBRYTA (daclizumab)***	
Oral Non-Interferons		
Category PA Criteria: A 3-month long trial of all preferred agents and Copaxone will be required before a non-preferred agent will be authorized. If patient has a documented intolerance, hypersensitivity, or labeled contraindication to Copaxone, a 3-month trial of interferon beta-1 is required for non-preferred agents. An FDA indication is required. Prescriber must be a neurologist.		
AUBAGIO (teriflunomide)	TECFIDERA (dimethyl fumarate)***	*** Tecfidera: Patient must have had a CBC with lymphocyte count within 6 months of request.
GILENYA (fingolimod)		
OPHTHALMIC ALPHA ADRENERGICS - GLAUCOMA		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: A 30-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. A 30-day trial of 2 preferred generics of the same medication will satisfy this requirement.		
ALPHAGAN P 0.1% (brimonidine)	Apraclonidine	
ALPHAGAN P 0.15% (brimonidine)	brimonidine 0.15%	
Apraclonidine	IOPIDINE (apraclonidine)	
brimonidine 0.2%		
COMBIGAN (brimonidine/timolol)		
SIMBRINZA (brinzolamide/brimonidine)		
OPHTHALMIC ANTIHISTAMINES		
Category PA Criteria: A 30-day trial of 3 preferred agents will be required before a non-preferred agent will be authorized.		
ALOCRIL (nedocromil)	ELESTAT (epinastine)	
ALOMIDE (lodoxamide)	EMADINE (emedastine)	
Azelastine	Olopatadine 0.2%	
BEPREVE (bepotastine)	PATANOL 0.1% (olopatadine)	
Cromolyn		
Epinastine		
LASTACAFT (alcaftadine)		
Olopatadine 0.1%		
PATADAY 0.2% (olopatadine)		
PAZEO (olopatadine)		
OPHTHALMIC ANTIINFECTIVES		
Category PA Criteria: A 3-day trial of 3 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
AZASITE (azithromycin) DROPS	Bacitracin ointment	
Bacitracin/polymyxin ointment	BLEPH-10 (sulfacetamide) DROPS	
BESIVANCE (besifloxacin) DROPS	CILOXAN (ciprofloxacin) DROPS	
CILOXAN (ciprofloxacin) OINTMENT	Gatifloxacin drops	
Ciprofloxacin drops	GENTAK (gentamicin sulfate) OINTMENT	
Erythromycin ointment	Levofloxacin drops	
Gentamicin sulfate drops	moxifloxacin drops	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Gentamicin sulfate ointment	NEO-POLYCIN (neomycin SU/bacitracin/polymyxin B) OINTMENT	
MOXEZA (moxifloxacin) DROPS	NEOSPORIN (neomycin SU/polymyxin B/gramicidin) DROPS	
Neomycin SU/bacitracin/polymyxin B ointment	OCUFLOX (ofloxacin) DROPS	
Neomycin SU/polymyxin B/gramicidin drops	POLYCIN (bacitracin/polymyxin) OINTMENT	
Ofloxacin drops	POLYTRIM (polymyxin B/trimethoprim) DROPS	
Polymyxin B/trimethoprim drops	Sulfacetamide ointment	
Sulfacetamide drops	TOBREX (tobramycin) DROPS	
Tobramycin drops	VIGAMOX (moxifloxacin) DROPS	
TOBREX (tobramycin) OINTMENT	ZYMAXID (gatifloxacin) DROPS	
OPHTHALMIC ANTIINFECTIVES/ANTIINFLAMMATORIES		
Category PA Criteria: A 7-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
Neomycin/bacitracin/polymyxin b/hydrocortisone ointment	BLEPHAMIDE (sulfacetamide/prednisolone) DROPS	
BLEPHAMIDE (sulfacetamide/prednisolone) DROPS	BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone) ointment	
Neomycin/polymyxin b/dexamethasone drops	MAXITROL (neomycin/polymyxin b/dexamethasone) DROPS	
Neomycin/polymyxin b/dexamethasone ointment	MAXITROL (neomycin/polymyxin b/dexamethasone) OINTMENT	
PRED-G (gentamicin/prednisol ac) DROPS	Neomycin/polymyxin b/hydrocortisone drops	
PRED-G (gentamicin/prednisol ac) OINTMENT	NEO-POLYCIN HC (neomycin SU/bacitracin/polymyxin B/hydrocortisone) OINTMENT	
Sulfacetamide/prednisolone drops	TOBRADEX ST (tobramycin/dexamethasone) DROPS	
TOBRADEX (tobramycin/dexamethasone) DROPS	Tobramycin/dexamethasone	
TOBRADEX (tobramycin/dexamethasone) OINTMENT		
ZYLET (tobramycin/lotepred etab) DROPS		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
OPHTHALMIC ANTIINFLAMMATORIES		
Category PA Criteria: A 5-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
ACUVAIL (ketorolac)	ACULAR (ketorolac)	
ALREX (loteprednol)	ACULAR LS (ketorolac)	
Diclofenac sodium	Bromfenac sodium	
FLAREX (fluorometholone)	BROMSITE (bromfenac sodium)	
Fluorometholone	Dexamethasone sodium phosphate	
Flurbiprofen sodium	DUREZOL (difluprednate)	
FML FORTE (fluorometholone)	FML (fluorometholone)	
FML S.O.P. (fluorometholone)	LOTEMAX (loteprednol) GEL DROPS	
ILEVRO (nepafenac)	LOTEMAX (loteprednol) OINTMENT	
ketorolac tromethamine 0.4%	NEVANAC (nepafenac)	
Ketorolac tromethamine 0.5%	OCUFEN (flurbiprofen)	
LOTEMAX (loteprednol) DROPS	OMNIPRED 1% (prednisolone acetate)	
MAXIDEX (dexamethasone)	PRED FORTE 1% (prednisolone acetate)	
PRED MILD 0.12% (prednisolone acetate)	Prednisolone acetate 1%	
Prednisolone sodium phosphate 1%	PROLENSA (bromfenac)	
OPHTHALMIC IMMUNOMODULATORS - DRY EYE SYNDROME		
Restasis (cyclosporine)		
Restasis multidose (cyclosporine)		
Xiidra (lifitegrast)		
OPIOID ANALGESIC - LONG ACTING		
Category PA Criteria: For non-preferred agents to be authorized: 1. Patient must have required around-the-clock pain relief for the past 90 days 2. The past 3 months of North Dakota PDMP reports must have been reviewed by the prescriber.		
butorphanol	ARYMO ER (oxycodone)***	*** Hysingla ER, oxymorphone ER, Zohydro ER require 30-day trials of fentanyl, morphine, and oxycodone products in addition to Category PA Criteria ***Belbuca- Patient must have failed 30-day trials of Butrans, Nucynta ER, and tramadol ER in additional to
BUTRANS (buprenorphine) PATCHES	BELBUCA (buprenorphine)***	
EMBEDA (morphine/naltrexone)	buprenorphine patches	
Fentanyl 12 mcg/hr[PA***]	DURAGESIC (fentanyl)	
Fentanyl 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	EXALGO (hydromorphone)***	

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Visit http://www.hidesigns.com/ndmedicaid for more information on medications not found in this list.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
levorphanol	Fentanyl patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr***	Category PA Criteria ***Hydromorphone ER and Exalgo – The 90-day around-the-clock pain relief requirement must be met by an equianalgesic dose of 60 mg oral morphine daily, 25 mcg transdermal fentanyl/hour, 30 mg oxycodone daily, 8 mg of oral hydromorphone daily, or another opioid daily. Patient must have failed 30-day trials of fentanyl, morphine, and oxycodone products in addition to Category PA Criteria ***Methadone, Fentanyl Patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr, morphine ER capsules, Arymo ER, Morphabond ER, and Oxycontin - Clinical justification must be given for why another product will not work in additional to Category PA Criteria. *** Fentanyl 12 mcg/hr – The total daily opioid dose must be less than 60 Morphine Equivalent Dose (MED) in additional to Category PA Criteria ***Tramadol ER Patient must have failed two 30-day trials of preferred medications in additional to Category PA Criteria ***Xtampza ER - Patient must have failed 30-day trials of fentanyl and morphine products in addition to Category PA Criteria
Morphine ER tablets	Hydromorphone ER tablets***	
NUCYNTA ER (tapentadol)	HYSINGLA ER (hydrocodone)***	
pentazocine-naloxone	KADIAN (morphine)***	
	Methadone***	
	MORPHABOND ER (morphine)***	
	Morphine ER capsules***	
	MS CONTIN (morphine)	
	Oxycodone ER***	
	OXYCONTIN (oxycodone)***	
	Oxymorphone ER tablets***	
	Tramadol ER	
	ULTRAM ER (tramadol ER)	
	XTAMPZA ER (oxycodone)***	
	ZOHYDRO ER (hydrocodone)***	
OPIOID ANTAGONIST - OPIOID AND ALCOHOL DEPENDENCE		
VIVITROL (Naltrexone Microspheres)		
OPIOID PARTIAL ANTAGONIST - OPIOID DEPENDENCE		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: A 30-day trial of 1 preferred agent will be required before a non-preferred agent will be authorized. 1. Patient must be 16 years of age or older. 2. Patient must not be taking other opioids, tramadol, or carisoprodol concurrently. 3. The prescriber must be registered to prescribe under the Substance Abuse and Mental Health Services Administration (SAMHSA) and provide his/her DEA number. 4. The prescriber and patient must have a contract or the prescriber must have developed a treatment plan. 5. The prescriber must perform routine drug screens. 6. The prescriber must routinely check the PDMP and the last 3 months of North Dakota PDMP reports must have been reviewed by the prescriber. 7. The prescriber must be enrolled with ND Medicaid.		
ZUBSOLV (buprenorphine/naloxone)[PA]	BUNAVAIL FILM (buprenorphine/naloxone)***	*** Bunavail/Suboxone Film will require a 30-day trial of buprenorphine/naloxone tablets in addition to the category PA criteria. ***Buprenorphine tablets will be allowed during a period that a patient is pregnant or breastfeeding.
	Buprenorphine tablets***	
	Buprenorphine-naloxone tablets	
	SUBOXONE FILM (buprenorphine/naloxone)***	
OTIC ANTI-INFECTIVES - FLUOROQUINOLONES		
Category PA Criteria: A 7-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized. A 7-day trial of 2 preferred generics of the same medication will satisfy this requirement.		
CIPRO HC (ciprofloxacin/hydrocortisone)	FLOXIN (ofloxacin)	
CIPRODEX (ciprofloxacin/dexamethasone)	Ofloxacin drops - labelers 50383, 60505	
OTOVEL (ciprofloxacin/fluocinolone)		
ofloxacin drops - labeler 24208		
PHOSPHATE BINDERS		
Category PA Criteria: The following criteria will be required before a non-preferred agent will be authorized: 1. Patient must have had a 3-month trial of 3 preferred different chemical entities. 2. Patient must have end stage renal disease or chronic kidney disease. 3. Patients with chronic kidney disease stage 5 must have a phosphate level greater than 5.5 mg/dL. 4. All other patients must have a phosphate level greater than 4.6 mg/dL.		
Calcium acetate capsule	AURYXIA (ferric citrate) TABLET	
Calcium acetate tablet	ELIPHOS (calcium acetate) TABLET	
FOSRENOL (lanthanum) 500 MG AND 750 MG CHEWABLE TABLET	FOSRENOL (lanthanum) 1000 MG CHEWABLE TABLET	
PHOSLYRA (calcium acetate) ORAL solution	FOSRENOL (lanthanum) POWDER PACK	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
RENAGEL (sevelamer) TABLET	Lanthanum	
RENVELA (sevelamer carbonate) TABLET	sevelamer powder pack	
RENVELA (sevelamer) POWDER PACK	VELPHORO (sucroferric oxyhydroxide)	
PLATELET AGGREGATION INHIBITORS		
Category PA Criteria: A 30 day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions is indicated on the form.		
AGGRENOX (aspirin/dipyridamole)	Aspirin/dipyridamole ER	***Zontivity – Patient must be 18 years of age or older. Zontivity must be taken with aspirin and/or clopidogrel. Patient must not have a history of stroke, transient ischemic attack, or intracranial hemorrhage. ***Durlaza/Yosprala DR – Patient must have a reason that immediate release aspirin is not an option.
BRILINTA (ticagrelor)	Clopidogrel 300mg	
Clopidogrel 75 mg	DURLAZA (aspirin ER)***	
Dipyridamole	EFFIENT (prasugrel)	
Ticlopidine	PERSANTINE (dipyridamole)	
	PLAVIX (clopidogrel)	
	prasugrel	
	YOSPRALA DR (aspirin/omeprazole)***	
	ZONTIVITY (vorapaxar)***	
PULMONARY HYPERTENSION		
PDE-5 Inhibitors		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. All medications require an FDA-approved indication. Patient cannot be taking nitrates of any form.		
Sildenafil[PA]	REVATIO (sildenafil) SUSPENSION***	***Revatio Suspension – Patients 7 years and older will be required to submit documentation of their inability to ingest a solid dosage form.
ADCIRCA (tadalafil)	REVATIO (sildenafil) TABLET	
Soluble Guanylate Cyclase Stimulators		
Category PA Criteria: All medications require an FDA-approved indication. Patients of childbearing potential must not be pregnant, be taking a reliable form of birth control, and have a pregnancy test before initiation and monthly during therapy. All medications require an FDA-approved indication. Patient may not be taking with nitrates of any form or specific (sildenafil or tadalafil) or non-specific (dipyridamole or theophylline) PDE-5 inhibitors.		
ADEMPAS (riociguat)[PA]		
Endothelin Receptor Antagonist		
Category PA Criteria: Patients of childbearing potential must not be pregnant, be taking a reliable form of birth control, and have a pregnancy test before initiation and monthly during therapy. All medications require an FDA-approved indication. Non-preferred agents will require a 30-day trial of all preferred medications.		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
TRACLEER (bosentan)PA***	LETAIRIS (ambrisentan)***	***Tracleer – LFTs must be measured at baseline and monthly during therapy. ***Opsumit - A 30 day trial of Letairis will be required in addition to category PA criteria
	OPSUMIT (macitentan)***	
Prostacyclins		
Category PA Criteria: All medications require an FDA-approved indication. A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
ORENITRAM ER (treprostinil)PA	TYVASO (treprostinil)	***Ventavis 20 mcg/mL – A patient must be maintained at a 5 mcg dose and repeatedly experiencing incomplete dosing due to extended treatment time to be approved.
REMODULIN (treprostinil)	UPTRAVI (selexipag)	
VENTAVIS (iloprost) 10 mcg/mLPA	VENTAVIS (iloprost) 20 mcg/mL***	
STEROID/LONG ACTING BETA AGONIST (LABA) COMBINATION INHALERS		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. Non-preferred agents must have an FDA-approved indication. For COPD diagnosis: EITHER both of the following will be required in addition to the category PA criteria: 1. A 30-day trial of Tudorza Pressair, Spiriva, Spiriva Respimat, Incruse Ellipta, or Seebri Neohaler 2. A 30-day trial of Brovana, Arcapta Neohaler, Striverdi Respimat, Perforomist, or Serevent. OR A 30-day trial of Anoro Ellipta, Stiolto Respimat, Utibron NeoHaler, Bevespi Aerosphere, or Trelegy Ellipta For asthma diagnosis, patient must have been reviewed for step down therapy for all renewal requests.		
ADVAIR DISKUS (fluticasone/salmeterol)	ADVAIR HFA (fluticasone/salmeterol)	***Airduo Respiclick - Clinical justification must be provided as to why Advair Diskus or Advair HFA will not work
DULERA (mometasone/formoterol)	AIRDUO RESPICLICK (fluticasone/salmeterol)***	
SYMBICORT (budesonide/formoterol)	BREO ELLIPTA (fluticasone/vilanterol)	
	fluticasone/salmeterol	
STEROIDs - INHALED		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: Inhalers: A 30-day trial of all preferred inhalers will be required before a non-preferred agent will be authorized. Inhaled suspensions (nebulizers): Non-preferred Brand medication: A 30-day trial of 2 pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized. Non-preferred Generic medication: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized.		
ALVESCO (ciclesonide)	AEROSPAN (flunisolide)	
ASMANEX (mometasone) TWISTHALER	ARMONAIR RESPICLICK (fluticasone)	
budesonide suspension 0.25 mg/2 mL	ARNUITY ELLIPTA (fluticasone)	
budesonide suspension 0.5 mg/2 mL	ASMANEX HFA (mometasone)	
FLOVENT HFA (fluticasone)	budesonide suspension 1 mg/2 mL	
PULMICORT FLEXHALER (budesonide)	FLOVENT DISKUS (fluticasone)	
PULMICORT RESPULES (budesonide) 1 MG/2 ML	PULMICORT RESPULES (budesonide) 0.25 mg/2 mL	
QVAR (beclomethasone)	PULMICORT RESPULES (budesonide) 0.5 mg/2 mL	
ULCERATIVE COLITIS AGENTS - NONSTEROIDAL		
Category PA Criteria: A 30-day trial of each of the preferred agents will be required before a non-preferred agent will be authorized. Non-preferred agents will require an FDA indication.		
Oral		
APRISO (mesalamine) CAPSULE	ASACOL HD (mesalamine)	***Giazo - Patient must be a male.
Balsalazide capsule	AZULFIDINE (sulfasalazine)	
DELZICOL (mesalamine) CAPSULE	AZULFIDINE DR (sulfasalazine)	
DIPENTUM (olsalazine)	COLAZAL (balsalazide)	
LIALDA (mesalamine) TABLET	GIAZO (balsalazide)***	
PENTASA (mesalamine)	Mesalamine DR	
Sulfasalazine DR tablet	SULFAZINE (sulfasalazine)	
Sulfasalazine tablet		
Rectal		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CANASA (mesalamine) RECTAL SUPPOSITORY	Mesalamine enema kit	
Mesalamine enema	ROWASA (mesalamine) ENEMA KIT	
SF ROWASA (mesalamine) ENEMA		
URINARY ANTISPASMODICS		
Category PA Criteria: A 30-day trial of 3 preferred agents will be required before a non-preferred agent will be authorized. Non-preferred agents require an FDA-approved indication.		
ENABLEX (darifenacin)	Darifenacin ER	***SANCTURA ER/Trospium ER and Myrbetriq will require a 1-month trial of trospium and tolterodine/tolterodine ER in addition to the category PA criteria.
Flavoxate	DETROL (tolterodine)	
GELNIQUE (oxybutynin)	DETROL LA (tolterodine)	
Oxybutynin ER	DITROPAN XL (oxybutynin)	
Oxybutynin syrup	MYRBETRIQ (mirabegron)***	
Oxybutynin tablet	SANCTURA (trospium)	
OXYTROL (oxybutynin) PATCH	SANCTURA ER (trospium)***	
TOVIAZ (fesoterodine)	Tolterodine	
VESICARE (solifenacin)	Tolterodine ER	
	Trospium	
	Trospium ER***	