



**DESOXYN PA FORM**  
SD DEPARTMENT OF SOCIAL SERVICES  
MEDICAL SERVICES DIVISION

Fax Completed Form to:  
**866-254-0761**  
For questions regarding this  
Prior authorization, call  
**866-705-5391**

SD Medicaid requires that patients receiving a new prescription for Desoxyn must meet the following criteria:

- Patient must be over 6 years of age.
- Diagnosis of Attention Deficit Disorder with Hyperactivity. (Desoxyn is not covered for the treatment of obesity)
- Four documented trials of the following options: a long-acting amphetamine salts product; a long-acting methylphenidate product; a long-acting product with a short-acting product; guanfacine; and atomoxetine.
- Trials within the last 90 days

**Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy)**

|   |                               |
|---|-------------------------------|
| RECIPIENT NAME:                               | RECIPIENT MEDICAID ID NUMBER: |
| Recipient<br>Date of birth:        /        / |                               |

**Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy)**

|                 |  |
|-----------------|--|
| PHYSICIAN NAME: | PHYSICIAN MEDICAID ID NUMBER:                  |
| City:           | FAX: (    )                      Phone: (    ) |

**Part III: TO BE COMPLETED BY PHYSICIAN**

|                        |  |
|------------------------|--|
| <b>REQUESTED DRUG:</b> | <b>Requested Dosage:</b> (must be completed) |
|                        | <b>Diagnosis for this request:</b>           |

**Qualifications for coverage:**

| <input type="checkbox"/> long-acting amphetamine salts                   | Drug Name/s | Start Date | End Date | Dose | Frequency |
|--|-------------|------------|----------|------|-----------|
| <input type="checkbox"/> long-acting methylphenidate                     |             |            |          |      |           |
| <input type="checkbox"/> long-acting product with a short-acting product |             |            |          |      |           |
| <input type="checkbox"/> guanfacine                                      |             |            |          |      |           |
| <input type="checkbox"/> atomoxetine                                     |             |            |          |      |           |

|                      |       |
|----------------------|-------|
| Physician Signature: | Date: |
|----------------------|-------|

**Part IV: TO BE COMPLETED BY PHARMACY**

|                |                              |
|----------------|------------------------------|
| PHARMACY NAME: | SD MEDICAID PROVIDER NUMBER: |
| Phone: (    )  | FAX: (    )                  |
| Drug:          | NDC#:                        |

**Part V: FOR OFFICIAL USE ONLY**

|   |   |
|---|---|
| Date:                      /                      /   | Initials: _____                                   |
| Approved -<br>Effective dates of PA:    From:                      /                      / | To:                      /                      / |
| Denied: (Reasons)   |   |