



QUALAQUIN
PRIOR AUTHORIZATION
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 Quaaliquin must have a diagnosis of malaria.

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

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH
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Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	
CITY:	PHONE: ()	FAX: ()

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: <input type="checkbox"/> Quaaliquin	Diagnosis for this request:
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ():	FAX: ()
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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