ARB 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 an ARB first try and fail one ACE Inhibitor. A PA may be given for one of the following reasons:

- **The patient has been stable on an ARB for greater than 60 days**
- **Patient has an additional diagnosis (such as COPD or RF) that precludes a trial with an ACE Inhibitor**
- **The provider has additional medical justification that supports first-line therapy with an ARB**

ARBs include: Atacand, Atacand/HCT, Avapro, Avalide, Benicar, Benicar/HCT, Cozaar, Diovan, Diovan/HCT, Edarbi, Hyzaar, Micardis, Micardis/HCT, Teveten, Teveten/HCT.

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

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient 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

REQUESTED DRUG:	**Requested Dosage:** (must be completed)
	Diagnosis for this request:

Qualifications for coverage:

Has patient been stable on requested ARB for more than 60 days? ❑ YES ❑ NO

Has patient tried and failed an ACE Inhibitor? ❑ YES ❑ NO

Does patient have a diagnosis of COPD or acute/chronic renal failure? ❑ YES ❑ NO

Medical Justification for use of an ARB without a trial of an ACEI:

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 - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	