ULTRAM ER/RYZOLT 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 have a trial of tramadol before receiving a PA for Ultram ER or Ryzolt.

- **Patients must use generic tramadol for a minimum of 30 days for the trial to be considered a failure.**
- **Ultram ER and Ryzolt will have a quantity limit of 30 tablets per month.**

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 DEA NUMBER:
City:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Dosage: (must be completed)

Diagnosis for this request:

Qualifications for coverage:

❑ Patient is currently stable on Ultram ER/Ryzolt

❑ Failed trial of tramadol	Was tramadol trial for at least 30 days? ❑ YES ❑ NO	Tramadol Dose:
		Tramadol Frequency:

Adverse Reaction (attach FDA MedWatch form) or contraindication to tramadol: (provide description below):

Medical Justification for use of Ultram ER or Ryzolt without trial of tramadol:

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)	