



**TARGETED IMMUNE MODULATORS  
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 Orencia, Humira, Enbrel, Amevive, Kineret, Cimzia, Remicade, and Simponi must submit a prior authorization form.

- Prior authorization will be granted if the requested product has been approved by the FDA for the indication listed.
- Physician administered medications do not require a prior authorization

**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:**

<b>Requested Drug and Dosage:</b> <input type="checkbox"/> Orencia _____ <input type="checkbox"/> Amevive _____ <input type="checkbox"/> Enbrel _____ <input type="checkbox"/> Kineret _____ <input type="checkbox"/> Humira _____ <input type="checkbox"/> Cimzia _____ <input type="checkbox"/> Remicade _____ <input type="checkbox"/> Simponi _____	<b>FDA approved indication for this request:</b> <input type="checkbox"/> Adult Rheumatoid Arthritis <input type="checkbox"/> Juvenile Idiopathic Arthritis <input type="checkbox"/> Plaque Psoriasis <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Psoriatic Arthritis <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Ulcerative Colitis
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)	