South Dakota Department of Social Services

Please note: All information below is required to process this request.
**Fax to 1-844-403-1029**
**Mon-Sat: 7am to 7pm Central**

# High Dollar/Claim Dollar Amount Override Prior Authorization Request Form

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

| Member Information (required) | | | Provider Information (required) | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

## Medication Information (required)

| Medication Name: | Strength: | Dosage Form: |
|---|---|---|
| ❑ Check if requesting **brand** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**What is the patient's diagnosis for the medication being requested?**

ICD-10 Code(s): _____

**What is the requested quantity per day/fill/prescription/ or month?** _____
Please indicate the daily dosages and the quantity requested per prescription/fill/ or month and the duration (i.e., 3 capsules per day, 4 capsules per prescription/per 30 days). Use/take as directed is not sufficient information.

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_____

_____

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.