South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-22941

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WEB: DSS Medicaid Prior Authorizations | **EMAIL :** DSSMedicaidpa@state.sd.us

ADUHELM PRIOR AUTHORIZATION REQUEST FORM

This form **MUST BE** submitted with medical records to support services

Date:		
RECEIPIENT INFORMATION		
Medicaid ID:	**Date of Birth:**	**Sex:** M ☐ F ☐
Last Name:	**First Name:**	
GENERAL INFORMATION		
First Date of Service:	**Last Date of Service:**	
Primary Diagnosis Code:	**HCPC Code:**	
Drug Name:	**Quantity:**	
Hospitalizations/Treatments/Medications Used in the last 6 months:		
POINT OF CONTACT		
Name and Title:		
Email:	**Phone:**	**Fax:**
***Note:** The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed point of contact.*		
REFERRING PROVIDER INFORMATION		
Name:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	
SERVICING PROVIDER INFORMATION		
Name:		
Address:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	

CRITERIA		
☐	**Medical records to support use of product are submitted**	
Initial Therapy (check one)	**Yes** ☐	**No** ☐
☐	Therapy is prescribed by a neurology provider	
☐	Individual is ≥ 50 years of age	
☐	Presence of amyloid beta disease pathology is confirmed with the use of either a PET scan or lumbar puncture prior to initiating treatment	
☐	Individual has mild cognitive impairment (MCI) or mild dementia as evidenced by **both** of the following: ☐ Mini-mental State Examination (MMSE) score of 24-30 ☐ Clinical Dementia Rating global score (CDR-GS) of ≤ 0.5	
☐	Documentation is provided that all other medical and neurological conditions that might contribute to the cognitive impairment have been ruled out	
☐	A recent (within one year) brain MRI has been performed prior to initiating treatment	
☐	Physician has a documented plan to obtain repeat brain MRIs prior to the 5th, 7th, 9th, and 12th infusion for monitoring of the development of amyloid related imaging abnormalities (ARIA)	
☐	Documentation is submitted showing failed trials (after at least 4 months) of continuous therapy, intolerance, or contraindication to **either** of the following: ☐ Cholinesterase inhibitor (e.g. donepezil) ☐ Memantine	
☐	None of the following are present: • Stroke, TIA, or unexplained loss of consciousness in the last year • Clinically significant unstable psychiatric illness in the past 6 months • History of unstable angina, myocardial infarction, advanced chronic heart failure, or clinically significant conduction abnormalities within the past year • Impaired renal or liver function • Significant systemic illness or infection in the past 30 days • Bleeding disorder, cerebrovascular abnormalities, or relevant brain hemorrhage • Contraindication to MRI or PET scans • Documentation of alcohol or substance abuse in the past year • Use of antiplatelet or anticoagulant (with the exception of aspirin at a dose ≤81mg)	
Continuation of Therapy (check one)	**Yes** ☐	**No** ☐
☐	Individual continues to meet initial criteria	
☐	Documented plan to obtain follow-up MRIs at the recommended intervals for monitoring of amyloid related imaging abnormalities (ARIA-E and ARIA-H) and appropriate plan if discovered	
☐	Repeat cognitive testing does not show presence of significant cognitive decline as demonstrated by **any** of the following: • MMSE ≤18 • CDR GS of ≥2	
PHYSICIAN SIGNATURE – PROVIDER ONLY		
This form must be signed by a neurologist		
☐	I certify that the information given in this form is a true and accurate medical indication for the required product	
Name & Title (Printed):		**Specialty:**
Signature:		