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WEB: [DSS Medicaid Prior Authorizations](#) | EMAIL : DSSMedicaidpa@state.sd.us

LENMELDY 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:		Dose & Frequency:
Hospitalizations/Treatments/Medications Used in the last 6 months:		
POINT OF CONTACT		
Name and Title:		
Email:	Phone:	Fax:
<small><i>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.</i></small>		
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 pediatric neurologist with expertise in the treatment of MLD	
	Individual has a diagnosis of MLD confirmed by all the following: <ul style="list-style-type: none"> • Arylsulfatase A (ARSA) activity below the normal range in peripheral blood mononuclear cells or fibroblasts • Genetic testing for biallelic ARSA pathogenic variants • Elevated urinary sulfatide levels 	
	Individual has a diagnosis of one of the following MLD subtypes: <ul style="list-style-type: none"> • Pre-symptomatic late infantile (PSLI) • Pre-symptomatic early juvenile (PSEJ) • Early symptomatic early juvenile (ESEJ) 	
	Individual can walk independently (if developmentally appropriate for age) and does not have cognitive decline as evidenced by an age-equivalent cognitive and verbal performance evaluation	
	Individual has not previously received hematopoietic stem cell gene therapy or if member has previously received hematopoietic stem cell transplant, there is no evidence of residual cells of donor origin	
	Prescriber attests individual does not have any of the following active diseases: hepatitis or HIV	
	Individual is <18 years of age and documentation is provided indicating symptom onset started before the age of 7	
PHYSICIAN SIGNATURE – PROVIDER ONLY		
This form <u>must be</u> signed by a provider		
	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:		