South Dakota Department of Social Services

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

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

H.P. ACTHAR PRIOR AUTHORIZATION REQUEST FORM

Use this form when therapy is requested for infantile spasms
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 requested by or in consultation with a neurologist		
☐	Individual has a diagnosis of infantile spasms (West Syndrome)		
☐	Individual is <2 years old		
Continuation of Therapy (check one)		**Yes** ☐	**No** ☐
☐	Documentation is submitted indicating that there was a positive response to therapy		
PHYSICIAN SIGNATURE – PROVIDER ONLY			
This form must be signed by a physician			
☐	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:			