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

H.P. ACTHAR PRIOR AUTHORIZATION REQUEST FORM

Use this form when therapy is requested for MS exacerbations
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**
	Individual is ≥18 years old
	Individual has a diagnosis of multiple sclerosis (MS)
	Documentation is provided indicating patient is having an acute MS exacerbation
	Documentation is submitted indicating previous failure, contraindication, or intolerance to oral and injectable glucocorticoids
	Documentation is provided indicting that individual is currently using disease modifying therapy for MS
Continuation of Therapy **(check one)**	**Yes** **No**
	Documentation is submitted indicating that there was a positive response to therapy
	Documentation is provided indicating need for continuation of therapy beyond acute exacerbation stage

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:	