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

PIASKY 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:**
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 hematologist, oncologist or immunologist		
☐	Individual has a documented diagnosis of PNH confirmed by flow cytometry		
☐	Individual is transfusion dependent as a result of PNH and documentation is provided indicating the frequency of transfusions		
☐	Documentation is provided indicating baseline values for hemoglobin and lactate dehydrogenase (LDH)		
☐	Documentation of one or more of the following indicating systemic complications: abdominal pain, dysphagia/odynophagia, shortness of breath, chest pain/pressure, hemoglobinuria, end organ damage, thrombosis, etc.		
☐	Documentation is provided indicating previous failure (≥3 months), contraindication, or intolerance to ravulizumab (Ultomiris)		
☐	Therapy will not be utilized in conjunction with other complement inhibitors (Ex. eculizumab, ravulizumab, pegcetacoplan, iptacopan, etc.)		
☐	Individual is ≥13 years of age		
☐	Individual is ≥40kg		
Continuation of Therapy (check one)		**Yes** ☐	**No** ☐
☐	Positive clinical response as indicated by **one or more** of the following: ☐ Stabilization or decrease in serum LDH from pretreatment baseline ☐ Stabilization/improvement in hemoglobin level from pretreatment baseline ☐ Decrease in packed RBC transfusion requirement from pretreatment baseline		
PHYSICIAN SIGNATURE – PROVIDER ONLY			
This form must be 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:			