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## PIASKY PRIOR AUTHORIZATION REQUEST FORM

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

Date:		
<b>RECEIPIENT INFORMATION</b>		
Medicaid ID:	Date of Birth:	Sex:    M        F
Last Name:		First Name:
<b>GENERAL INFORMATION</b>		
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:		
<b>POINT OF CONTACT</b>		
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>		
<b>REFERRING PROVIDER INFORMATION</b>		
Name:		
NPI #:		Taxonomy:
Phone:		Fax:
<b>SERVICING PROVIDER INFORMATION</b>		
Name:		
Address:		
NPI #:		Taxonomy:
Phone:		Fax:

<b>CRITERIA</b>		
<b>Medical records to support use of product are submitted</b>		
<b>Initial Therapy (check one)</b>	<b>Yes</b>	<b>No</b>
	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.	
	Therapy is not prescribed in combination with other biologics for PNH (Ex. eculizumab, ravulizumab, pegcetacoplan, iptacopan, etc.)	
	Individual is ≥13 years of age	
	Individual is ≥40kg	
<b>Continuation of Therapy (check one)</b>	<b>Yes</b>	<b>No</b>
	Therapy is not prescribed in combination with other biologics for the requested indication	
	Individual has had a positive clinical response as indicated by <b>one or more</b> of the following: <ul style="list-style-type: none"> <li>• Stabilization or decrease in serum LDH from pretreatment baseline</li> <li>• Stabilization/improvement in hemoglobin level from pretreatment baseline</li> <li>• Decrease in packed RBC transfusion requirement from pretreatment baseline</li> </ul>	
<b>PHYSICIAN SIGNATURE – PROVIDER ONLY</b>		
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	
<b>Name &amp; Title (Printed):</b>		<b>Specialty:</b>
<b>Signature:</b>		