South Dakota Department of Social Services

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

PHONE: 605-773-3495 | FAX: 605-773-5246
WEB: DSS Medicaid Prior Authorizations | **EMAIL :** DSSMedicaidpa@state.sd.us

ELEVIDYS 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:	**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 prescribed by with a neurologist who specializes in the treatment of DMD and/or other neuromuscular disorders
☐	Individual has a diagnosis of DMD confirmed by genetic testing
☐	Individual does not have any deletion in exon 8 and/or exon 9 DMD gene
☐	Individual is ambulatory (e.g. is not dependent on assistive devices and is not wheelchair dependent) and has a North Star Ambulatory Assessment (NSAA) score documented at baseline
☐	Individual is 4-7 years of age
☐	Individual meets one of the following regarding DMD antisense oligonucleotides ☐ Individual is not currently taking any DMD antisense oligonucleotides ☐ DMD antisense oligonucleotide therapy will be discontinued prior to Elevidys infusion
☐	Baseline labs are completed and anti-AAVrh74is not ≥1:400
☐	Individual has not received Elevidys therapy in the past
PHYSICIAN SIGNATURE – PROVIDER ONLY	
This form must be signed by a neurologist	
☐	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:	