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

SOLIRIS PRIOR AUTHORIZATION REQUEST FORM

Use this form when therapy is requested for neuromyelitis optica spectrum disorder (NMOSD)
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 is ≥18 years of age	
☐	Individual has a documented diagnosis of NMOSD with presence of seropositive aquaporin-4 (AQP4) antibodies	
☐	Individual has symptoms consistent with at least **one** core clinical characteristic below: ☐ Optic neuritis ☐ Acute myelitis ☐ Area postrema syndrome or episode of otherwise unexplained hiccups or nausea and vomiting ☐ Acute brainstem syndrome ☐ Symptomatic narcolepsy ☐ Acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions ☐ Symptomatic cerebral syndrome with NMOSD-typical brain lesions	
☐	Documentation is provided indicating previous failure, contraindication, or intolerance to **at least two** of the following therapies (with at least one of them being a C5 complement inhibitor): ☐ Rituximab ☐ Tocilizumab ☐ Inebilizumab (Uplizna) ☐ Satralizumab-mwge (Enspryng)	
☐	Therapy is not being used in combination with other biologics for NMOSD (inebilizumab, rituximab, satralizumab, tocilizumab, etc.)	
☐	Individual has an Expanded Disability Status Score (EDSS) score documented at baseline	
☐	Individual has a history of at least 2 relapses in last 12 months or 3 relapses in the last 24 months with at least 1 relapse in the last 12 months	
Continuation of Therapy (check one)	**Yes** ☐	**No** ☐
☐	Individual continues to meet initial criteria	
☐	Positive clinical response including maintained or improved EDSS score, decreased relapse rate	
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:		