



PHONE: 605-773-3495 | FAX: 605-773-5246

WEB: [DSS Medicaid Prior Authorizations](#) | EMAIL : DSSMedicaidpa@state.sd.us

ECULIZUMAB PRIOR AUTHORIZATION REQUEST FORM

Use this form when therapy is requested for atypical hemolytic uremic syndrome (aHUS)

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:
<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>		
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
	Claim is for a preferred product or individual has already stepped through a preferred product (≥3 month trial) unless otherwise specified below	
	Therapy is requested by or in consultation with a hematologist or nephrologist	
	Individual has a documented diagnosis of aHUS that is not Shiga toxin E. coli related	
	Individual is ≥ 5 kg	
	Documentation is provided indicating baseline values for the following: <ul style="list-style-type: none"> • Serum lactate dehydrogenase (LDH) • Serum creatinine/eGFR • Platelet count • Frequency of plasma exchange/infusion requirement 	
	Individual has documented failure or contraindication to Ravulizumab (Ultomiris)	
	Therapy is not prescribed in combination with other biologics for aHUS (e.g.Ultomiris)	
Continuation of Therapy (check one)	Yes	No
	Therapy is not prescribed in combination with other biologics for the requested indication	
	Individual has had a positive clinical response as indicated by one or more of the following: <ul style="list-style-type: none"> • Decrease in serum LDH from pretreatment baseline • Stabilization/improvement in renal function (serum creatinine/eGFR) from pretreatment baseline • Increase in platelet count from pretreatment baseline • Decrease in plasma exchange/infusion requirement from pretreatment baseline 	
PHYSICIAN SIGNATURE – PROVIDER ONLY		
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	
Name & Title (Printed):		Specialty:
Signature:		