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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SOLIRIS PRIOR AUTHORIZATION REQUEST FORM

Use this form when therapy is requested for anti-ACHR+ generalized myasthenia gravis (gMG)
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 gMG with labs confirming presence of anti-ACHR antibodies	
☐	Individual has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of Class II-IV disease	
☐	Documentation is submitted indicating the patient's Baseline Quantitative Myasthenia Gravis (QMG) score	
☐	MG-Activities of Daily Living (MG-ADL) total score of ≥6	
☐	Documentation is provided indicating inadequate response or contraindication to pyridostigmine and corticosteroids	
☐	Individual has failed treatment with at least 2 immunosuppressive therapies (ex., azathioprine, cyclosporine, mycophenolate, cyclophosphamide, methotrexate, tacrolimus etc.) over the course of the last 12 months OR has failed at least 1 immunosuppressive therapy and required chronic plasmapheresis, plasma exchange (PE) or intravenous immunoglobulin (IVIG)	
☐	Documentation is provided indicating previous failure, contraindication or intolerance to Efgartigimod alfa (Vyvgart) and Ravulizumab (Ultomiris)	
Continuation of Therapy (check one)	**Yes** ☐	**No** ☐
☐	Individual continues to meet initial criteria	
☐	Improvement (reduction in score) in the Myasthenia Gravis-Specific Activities of Daily Living scale (MG-ADL) total score from pretreatment baseline	
☐	Improvement in the Quantitative Myasthenia Gravis (QMG) total score	
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:		