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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WEB: DSS Medicaid Prior Authorizations | **EMAIL :** DSSMedicaidpa@state.sd.us

RADICAVA 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 or in consult with a neurologist		
☐	Individual has a documented diagnosis of ALS		
☐	Individual has a Japanese ALS Severity Scale grade of 1 or 2		
☐	Onset of ALS has been <2 years since time of therapy initiation		
☐	Baseline ALS Functional Rating Scale-Revised (ALSFRS-R) is provided and indicates a score of ≥2 in all areas		
☐	Documentation is provided indicating forced vital capacity (FVC) >80%		
☐	Individual is ≥18 years of age		
Continuation of Therapy (check one)		**Yes** ☐	**No** ☐
☐	Individual continues to meet all initial criteria		
☐	Japanese ALS Severity Scale grade documented at time of therapy renewal		
☐	ALS Functional Rating Scale-Revised (ALSFRS-R) scores documented at time of renewal		
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:			