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

SKYSONA 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:	**Dose & Frequency:**	
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 a neurologist or transplant specialist
☐	Individual is a biologic male and between the ages of 4-17 years
☐	Individual has a diagnosis of cerebral adrenoleukodystrophy confirmed by **both** of the following: ☐ Genetic confirmation of the *ABCD1* mutation ☐ Elevated levels of very long chain fatty acids (VLCFA)
☐	Individual has early, active disease as evidenced by a Loes score of ≥0.5- ≤0.9 and gadolinium enhancement of demyelinating lesions on MRI
☐	Documentation is submitted indicating neurologic function score (NFS) ≤1
☐	Individual is not currently taking statins or other dietary regimens to lower VLCFA levels
☐	Attestation from provider that member is clinically stable and able to undergo gene therapy
☐	Screening has been done within the last 6 months and documentation is provided indicating that the individual is negative for the following active diseases: HIV, Hepatitis B, and Hepatitis C
☐	Individual does not have a known, human leukocyte antigen (HLA)-matched donor
☐	Individual does not have renal compromise as evidenced by abnormal renal function (actual or calculated creatinine clearance < 50 ml/min
☐	Individual does not have cardiac compromise as evidenced by left ventricular ejection fraction <40 percent (%)
☐	Individual has not previously received a hematopoietic stem cell transplant or prior gene therapy
☐	Individual does not have advanced liver disease (defined as AST >2.5x upper limit of normal (ULN), ALT > 2.5x ULN, or total bilirubin value > 3.0 milligram per deciliter (mg/dL), except if there is a diagnosis of Gilbert's Syndrome and the participant is otherwise stable)
☐	If female, documentation of negative pregnancy test must be submitted prior to therapy
☐	Male and female members of reproductive potential must use an effective method of contraception at start of treatment and at least 6 months following Skysona administration
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:	