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

HEMGENIX 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 a hematologist		
☐	Individual has a diagnosis of hemophilia B (congenital Factor IX deficiency) confirmed via factor IX assay		
☐	Disease severity is classified as moderate to severe with Factor IX levels ≤5% of normal		
☐	Individual was assigned male sex at birth and is ≥18 years of age		
☐	Individual meets **one** of the following with regard to necessity for Factor IX therapy: ☐ Current use of Factor IX prophylaxis therapy (e.g., AlphaNine SD, Alprolix, BeneFIX, Idelvion, Ixinity, Mononine, Profilnine SD, Rebinyn, Rixubis) and has had a minimum of 150 exposure days OR the prescriber has determined that the patient requires improved protection in addition to current therapy due to unavoidable risks (e.g., patients with increased bleeding due to severely damaged joints, patients with increased bleeding due to need for anticoagulation, elderly patients with risk for falls) ☐ Current or historical life-threatening hemorrhage ☐ History of repeated, serious spontaneous bleeding episodes		
☐	Documentation is provided showing individual is negative for Factor IX inhibitor titers within the last 30 days		
☐	Documentation is provided indicating that baseline liver function tests (AST, ALT and total bilirubin) were performed and determined to be within normal limits (if there is evidence of liver abnormalities, sign off from a hepatologist indicating eligibility for Hemgenix is required before SD Medicaid will approve prior authorization request)		
☐	Individual has not received prior gene therapy		
PHYSICIAN SIGNATURE – PROVIDER ONLY			
This form must be signed by a hematologist			
☐	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:			