



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

ELAPRASE 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:
<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>		
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 geneticist with expertise in the treatment of mucopolysaccharidosis	
	Individual has a diagnosis of mucopolysaccharidosis II (Hunter syndrome) demonstrated by one of the following : • Enzyme assay demonstrating a deficiency in iduronate 2-sulfatase enzyme activity as measured in fibroblasts or leukocytes combined with normal enzyme activity of another sulfatase • Genetic testing confirming an iduronate 2-sulfatase gene mutation	
	Individual is ≥16 months of age	
	Baseline disease is documented with one of the following : • Urinary glycosaminoglycan (uGAG) levels are elevated defined by laboratory reference range • Baseline 6-minute walk test (6MWT) • Hepatomegaly (liver size ≥1.25x normal) • Splenomegaly (spleen size >5x normal)	
Continuation of Therapy (check one)	Yes	No
	Individual has had a positive response to therapy	
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:		