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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UPLIZNA PRIOR AUTHORIZATION REQUEST FORM

Use this form when therapy is requested for Immunoglobulin G4-related (IGG4) disease
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** ☐
☐	Individual is ≥18 years of age	
☐	Therapy is prescribed by or in consultation with a rheumatologist, gastroenterologist, nephrologist, or pulmonologist	
☐	Individual has a diagnosis of immunoglobulin G4-related disease	
☐	Individual meets **one** of the following: ☐ Documentation is submitted indicating at least 1 organ system involvement in addition to failure, contraindication, and/or current use of steroids with progression of symptoms ☐ Documentation is submitted indicating multisystem (≥2) organ involvement and concurrent initiation of steroid therapy	
☐	Documentation is provided indicating previous failure, contraindication or intolerance to rituximab	
Continuation of Therapy (check one)	**Yes** ☐	**No** ☐
☐	Therapy is not prescribed in combination with other biologics for the requested indication	
☐	Individual has had positive response to therapy as indicated by improvement in symptoms, disease flares and/or need for corticosteroids	
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:		