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

INFLIXIMAB 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		
Requested therapy:	**Date of therapy start:**	
HCPC Code:	**Dose & Frequency:**	
Diagnosis Code:		
Reason preferred product cannot be used:		
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 meets **one** of the following regarding previous therapy trials: ☐ Member has failed a ≥90 day trial for a preferred medication ☐ Clinical justification is provided why the member cannot utilize a preferred product		
Continuation of Therapy (check one)		**Yes** ☐	**No** ☐
☐	Requested drug remains the preferred product with SD Medicaid		
☐	Reason for initial approval is still present		
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:			