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WEB: [DSS Medicaid Prior Authorizations](#) | EMAIL : DSSMedicaidpa@state.sd.us

AMTAGVI 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:
<small><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></small>		
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 an oncologist
	Individual has a diagnosis of melanoma
	Disease is classified as unresectable or metastatic and documentation is provided that the individual has failed a PD-1 blocking antibody and, if <i>BRAF</i> V600 mutation positive, a BRAF inhibitor with or without a MEK inhibitor
	Individual is ≥18 years of age
	Member has not received an organ allograft, Car-T or TIL therapy in the past and therapy will not be utilized in conjunction with Car-T therapies
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:	