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

REBLOZYL 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 or in consultation with a hematologist or oncologist	
	Individual has a diagnosis of one of the following: <ul style="list-style-type: none"> • Beta thalassemia • Myelodysplastic syndrome 	
	Individual is anemic and transfusion dependent and documentation is provided indicating the frequency of transfusions	
	If using for myelodysplastic syndrome, documentation of one of the following is provided: <ul style="list-style-type: none"> • Individual has had inadequate response to prior treatment with an erythropoiesis stimulating agent (ESA) • Serum erythropoietin level >200U/L 	
	Individual is ≥18 years of age	
	Individual has not previously received gene therapy for beta-thalassemia (Ex. Casgevy or Zynteglo)	
Continuation of Therapy (check one)	Yes	No
	Documentation is provided indicating decrease in transfusion burden compared to baseline	
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:		