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

IMAAVY 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:**
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** ☐
☐	Therapy is requested by or in consultation with a neurologist	
☐	Individual is ≥ 12 years of age	
☐	Individual has a documented diagnosis of gMG with labs confirming the presence of **one** of the following: ☐ Anti-AChR antibodies ☐ Anti-MuSK antibodies	
☐	Individual has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of Class II-IV disease	
☐	Documentation is submitted indicating the patient's baseline Quantitative Myasthenia Gravis (QMG) score	
☐	MG-Activities of Daily Living (MG-ADL) total score of ≥6	
☐	Individual meets previous therapy trials as specified per indication ☐ AChR+ Disease(must meet all): ☐ Documentation is provided indicating inadequate response or contraindication to pyridostigmine and corticosteroids ☐ Individual has failed treatment with at least 2 immunosuppressive therapies (ex., azathioprine, cyclosporine, mycophenolate, cyclophosphamide, methotrexate, tacrolimus etc.) over the course of the last 12 months OR has failed at least 1 immunosuppressive therapy and required chronic plasmapheresis, plasma exchange (PE) or intravenous immunoglobulin (IVIG) ☐ Documentation is provided indicating previous failure, contraindication or intolerance to inebilizumab (Uplizna) ☐ MuSK+ Disease (must meet all): ☐ Documentation is provided indicating inadequate response or contraindication to corticosteroids ☐ Documentation is provided indicating failure, contraindication or inadequate response to rituximab ☐ Documentation is provided indicating previous failure, contraindication or intolerance to inebilizumab (Uplizna)	
☐	Therapy is not prescribed in combination with other biologics for gMG (e.g. Ultomiris, Zilbrysq, Rystiggo, Vyvgart, Vyvgart Hytrulo, etc.)	
Continuation of Therapy (check one)	**Yes** ☐	**No** ☐
☐	Improvement (reduction in score) in the Myasthenia Gravis-Specific Activities of Daily Living scale (MG-ADL) total score from pretreatment baseline	
☐	Improvement in the Quantitative Myasthenia Gravis (QMG) total score	
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:		