



PHONE: 605-773-3495 | FAX: 605-773-5246

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

AUCATZYL 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 a hematologist or oncologist	
	Individual has a diagnosis of B cell precursor, acute lymphoblastic leukemia	
	Disease is classified as relapsed or refractory	
	Individual is ≥18 years of age	
	Member has not received Car-T therapy in the past and therapy will not be utilized in conjunction with other 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:		