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

# OCREVUS 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:** | **Quantity:** | |
| **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** ☐ |
| ☐ | Individual has a diagnosis of primary progressive or relapsing forms of MS | |
| ☐ | Therapy is prescribed by or in consultation with a neurologist | |
| ☐ | Individual is >18 years of age | |
| ☐ | Documentation is provided indicating screening for hepatitis B virus and quantitative serum immunoglobulin | |
| ☐ | Therapy is not being used in combination with other MS disease modifying therapies | |
| ☐ | If treating relapsing MS, individual meets **one** of the following:<br>☐ Previous trial in the past 12 months of at least two MS disease modifying drug therapies that were not tolerated or ineffective as evidenced by disease progression OR explanation of contraindications for other MS disease modifying drug therapies<br>☐ Documented need to use as first line therapy due to severity of MS or if they are at higher risk of poor long-term outcome (those with spinal cord involvement, highly active disease, poor relapse recovery, etc.) | |
| **Continuation of Therapy (check one)** | **Yes** ☐ | **No** ☐ |
| ☐ | Individual continues to meet initial criteria | |
| ☐ | Documentation is provided indicating disease improvement or stabilization | |
| **PHYSICIAN SIGNATURE – PROVIDER ONLY** | | |
| This form must be signed by a physician | | |
| ☐ | 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:** | | |