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

RANIBIZUMAB 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:**	**Requested Eye:** R ☐ L ☐
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 prescribed by or in consultation with an ophthalmologist	
☐	Individual has a diagnosis of **one** of the following and therapy choice corresponds with an FDA labeled indication as listed below: ☐ Diabetic macular edema: Lucentis, Cimerli, Susvimo ☐ Diabetic retinopathy: Lucentis, Cimerli ☐ Macular edema following retinal vein occlusion: Lucentis, Cimerli, Byooviz ☐ Age-related macular degeneration: Lucentis, Cimerli, Byooviz, Susvimo ☐ Myopic choroidal neovascularization: Lucentis, Cimerli, Byooviz	
☐	Individual has a documented best corrected visual acuity (BCVA) score of 20/40 or worse within the last 12 months	
☐	Individual has failed therapy (≥90 days) with intravitreal bevacizumab	
☐	For Susvimo only: individual has previously responded to at least 2 intravitreal injections of a VEGF inhibitor	
☐	Individual is ≥18 years of age	
Continuation of Therapy (check one)	**Yes** ☐	**No** ☐
☐	Documentation is submitted indicating positive response to therapy as demonstrated by a maintained or improved BCVA 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:		