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

EVENITY 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** ☐
☐	Individual is a postmenopausal female	
☐	Individual has documented diagnosis of osteoporosis and has a very high risk for fracture based on at least **one** of the following: ☐ T score ≤-2.5 plus a fragility fracture ☐ History of severe or multiple fractures ☐ Individual has documented allergy/contraindication or failure (defined as disease progression after ≥24 months of therapy) with both a bisphosphonate and RANKL blocking agent	
☐	Documentation is submitted indicating any hypocalcemia and vitamin D deficiencies have been corrected prior to starting therapy with Evenity	
☐	Individual has not been treated with Evenity therapy in the past or the previous trial was <12 months	
☐	Individual has not had a myocardial infarction or stroke in the last 12 months	
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:		