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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# RYSTIGGO 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** ☐ |
| ☐ | Therapy is requested by or in consultation with a neurologist | |
| ☐ | Individual is ≥18 years of age | |
| ☐ | Individual has a documented diagnosis of gMG with labs confirming the presence of **one** of the following:<br>☐ Anti-AChR Antibodies<br>☐ 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 ≥3 | |
| ☐ | Individual meets previous therapy trials as specified per indication<br>☐ AChR+ Disease<br>☐ Documentation is provided indicating inadequate response or contraindication to pyridostigmine and corticosteroids<br>☐ 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)<br>☐ Individual has failed treatment with efgartigimod alfa (Vyvgart) and ravulizumab (Ultomiris)<br>☐ MuSK+ Disease<br>☐ Documentation is provided indicating inadequate response or contraindication to corticosteroids<br>☐ Documentation is provided indicating failure, contraindication or inadequate response to rituximab | |
| ☐ | Individual is not using in combination with other myasthenia gravis therapies (Ex. Vyvgart, Ultomiris, Soliris) | |
| **Continuation of Therapy (check one)** | **Yes** ☐ | **No** ☐ |
| ☐ | Individual continues to meet initial criteria | |
| ☐ | Individual has had a positive response to therapy as indicated by a reduction in the Myasthenia Gravis-Specific Activities of Daily Living scale (MG-ADL) 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:** | | |