South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-22941

PHONE: 605-773-3495 | FAX: 605-773-5246
WEB: DSS Medicaid Prior Authorizations | **EMAIL :** DSSMedicaidpa@state.sd.us

ENJAYMO 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** ☐
☐	Prescribed by or in consultation with a hematologist	
☐	Individual is ≥18 years of age	
☐	Individual has a confirmed diagnosis of CAD based on **all** the following: ☐ Chronic hemolysis (Ex. elevated lactated dehydrogenase [LDH], decreased haptoglobin, increased indirect bilirubin, increased reticulocyte count) ☐ Positive polyspecific direct antiglobulin test (DAT) ☐ Positive monospecific DAT specific for C3d ☐ Cold agglutinin titer greater than or equal to 64 (1:64) at 4°C ☐ IgG DAT less than or equal to 1+ ☐ Presence of one or more symptoms associated with CAD (i.e. symptomatic anemia, acrocyanosis, Raynaud's phenomenon, hemoglobinuria, disabling circulatory symptoms, or a major adverse vascular event)	
☐	Documentation is submitted indicating baseline hemoglobin ≤10 g/dL	
☐	Individual meets one of the following in regards to indication for therapy: ☐ Therapy is being utilized in the emergency setting due to hemolysis ☐ Individual has a failure, contraindication or intolerance to a rituximab containing regimen ☐ Individual has hemolytic anemia that is unresponsive to B cell-directed therapies	
☐	Therapy is not being utilized in combination with other complement inhibitors [e.g., Soliris (eculizumab), Ultomiris (ravilizumab-cwzb), Empaveli (pegcetacoplan)	
☐	Individual has not received rituximab within three (3) months of initiation and will not be using rituximab with sutimlimab-jome (Enjaymo)	
☐	Cold agglutinin disease secondary to other factors has been ruled out (e.g. infection, rheumatologic disease, systemic lupus erythematosus, or overt hematologic malignancy)	
Continuation of Therapy (check one)	**Yes** ☐	**No** ☐
☐	Individual continues to meet initial therapy	
☐	Documentation of positive response to therapy by hemoglobin increase of ≥ 1.5 g/dL from pre-treatment baseline OR hemoglobin level ≥12 g/dL and **one** of the following: ☐ Reduction in transfusion requirement (if previously transfusion dependent) after starting sutimlimab therapy ☐ Improvement in anemia related symptoms	
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:		