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

TZIELD 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 prescribed or in consultation with an endocrinologist	
☐	Individual is ≥8 years of age	
☐	Individual has **at least two** positive pancreatic islet autoantibodies: ☐ Glutamic acid decarboxylase 65 (GAD) autoantibodies ☐ Insulin autoantibody (IAA) ☐ Insulinoma-associated antigen 2 autoantibody (IA-2A) ☐ Zinc transporter 8 autoantibody (ZnT8A) ☐ Islet cell autoantibody (ICA)	
☐	Individual has stage 2 T1DM disease confirmed by glucose intolerance using an oral glucose tolerance test (OGTT) (or alternative method if appropriate and OGTT is not available) indicating **one** of the following in the previous 2 months: ☐ Fasting glucose 110-125 mg/dL ☐ 2-hour postprandial plasma glucose 140-199 mg/dL ☐ An intervening postprandial glucose level at 30, 60, or 90 minutes of ≥ 200 mg/dL	
☐	Individual does not have a suggestion of T2D and has not progressed to stage 3 T1DM	
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:		