



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

KYMRIAH 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:
<i>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.</i>		
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 a hematologist or oncologist	
	Individual has a diagnosis of one of the following: <ul style="list-style-type: none"> • B cell precursor, acute lymphoblastic leukemia • Diffuse large B-cell lymphoma • Follicular lymphoma 	
	Individual meets one of the following regarding disease severity/previous therapy failures: <ul style="list-style-type: none"> • B cell precursor, acute lymphoblastic leukemia (must meet one): <ul style="list-style-type: none"> ○ Disease is classified as refractory, defined as failure to achieve complete response after ≥ 2 cycles of chemotherapy (primary refractory) or after 1 cycle of chemotherapy for relapsed leukemia (chemorefractory) ○ Member has had ≥ 2 relapses ○ Disease is relapsed or refractory, Philadelphia chromosome positive (Ph+): member has failed ≥ 2 lines of chemotherapy that included 2 tyrosine kinase inhibitors ○ Member has relapsed following allogenic stem cell transplantation (SCT) and must be ≥ 6 months out from SCT at the time of Kymriah infusion • Diffuse large B-cell lymphoma (including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, high-grade B-cell lymphoma and DLBCL arising from follicular lymphoma): disease is relapsed or refractory and documentation is provided indicating failure of 2 or more lines of systemic therapy • Follicular lymphoma: disease is relapsed or refractory and documentation is provided indicating failure of ≥ 2 lines of systemic therapy or autologous hematopoietic stem cell transplant 	
	Member has not received Car-T therapy in the past and therapy will not be utilized in conjunction with other Car-T therapies	
	Individual is ≥ 18 years of age if therapy is requested for diffuse large B-cell lymphoma or follicular lymphoma and ≤ 25 years of age for acute lymphoblastic leukemia	
PHYSICIAN SIGNATURE – PROVIDER ONLY		
This form <u>must be</u> 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:		