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

# QALSODY 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 by or in consult with a neurologist | |
| ☐ | Individual has a diagnosis of ALS with documentation supporting **both** of the following<br>☐ Muscle weakness attributed to ALS<br>☐ Documentation of SOD1 mutation | |
| ☐ | Baseline ALS Functional Rating Scale-Revised (ALSFRS-R) is provided and indicates a score of ≥2 in all areas | |
| ☐ | Individual has a baseline slow vital capacity (SVC) of ≥50% of predicted value for age, sex and height (from sitting position) | |
| ☐ | Individual is not ventilator dependent | |
| ☐ | Individual is ≥18 years of age | |
| **Continuation of Therapy (check one)** | **Yes** ☐ | **No** ☐ |
| ☐ | Individual continues to meet initial criteria and remains non-ventilator dependent | |
| ☐ | Japanese ALS Severity Scale grade documented at time of therapy renewal | |
| ☐ | ALS Functional Rating Scale-Revised (ALSFRS-R) scores documented at time of renewal | |
| **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:** | | |