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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:		Dose & Frequency:
Hospitalizations/Treatments/Medications Used in the last 6 months:		
POINT OF CONTACT		
Name and Title:		
Email:	Phone:	Fax:
<small><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></small>		
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 <ul style="list-style-type: none"> • Muscle weakness attributed to ALS • 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 $\geq 50\%$ 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 <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:		