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

ROCTAVIAN 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** ☐
☐	Therapy is prescribed by a hematologist
☐	Individual has a diagnosis of hemophilia A (congenital Factor VIII deficiency) confirmed via factor VIII assay
☐	Disease is classified as severe with pre-treatment Factor VIII levels ≤1% of normal
☐	Individual was assigned male sex at birth and is ≥18 years of age
☐	Individual has been adherent with Factor VIII prophylaxis therapy for at least 12 months and has had at least one serious spontaneous bleeding event (within the last 12 months) while on routine prophylaxis
☐	Documentation is submitted indicating the individual has a minimum of 150 exposure days to Factor VIII therapy
☐	Documentation is provided showing individual is negative for Factor VIII inhibitor titers as shown by an assay level of <0.6 Bethesda units (BU) on 2 separate occasions (at least a week apart) within the last 12 months
☐	Documentation is submitted indicating individual has been tested for presence of anti-adeno-associated virus serotype 5 (AAV5) antibodies and is negative
☐	Individual does not have advanced liver disease (defined as ALT, AST, gamma glutamyl transferase, total bilirubin or alkaline phosphatase >1.25x upper limit of normal, international normalized ratio ≥1.4 or significant liver fibrosis (defined as prior liver biopsy showing fibrosis of 3 or 4 as rated on a scale of 1-4 on the Batts-Ludwig or METAVIR scoring systems, or an equivalent grade of fibrosis if an alternative scale was used)
☐	Evidence of any bleeding disorder not related to Hemophilia A has been ruled out
☐	Provider confirms that the member will discontinue any use of hemophilia A prophylactic therapy within 4 weeks after Roctavian administration
☐	If female, documentation of negative pregnancy test must be submitted prior to therapy
☐	Male and female members of reproductive potential must use an effective method of contraception at start of treatment and at least 6 months following Roctavian administration
☐	Prescriber attests individual does not have any of the following active diseases: hepatitis B or C, or decompensated cirrhosis
☐	Individual is not HIV positive
☐	Individual has not received prior gene therapy
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:	