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

LUXTURNA 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**		
Treatment location (check one)	**Right Eye** ☐	**Left Eye** ☐	**Both Eyes** ☐
	Note: *Authorization can be given for both eyes if dates and plan are specified for each surgery OR authorization must be obtained for each eye separately*		
Initial Therapy (check one)	**Yes** ☐	**No** ☐	
☐	Therapy is prescribed by an ophthalmologist or retinal specialist/surgeon		
☐	Individual is ≥12 months of age		
☐	Individual has a confirmed diagnosis of biallelic RPE65 mutation-associated retinal dystrophy such as Leber's congenital amaurosis (LCA), retinitis pigmentosa (RP) or early onset severe retinal dystrophy (EOSRD)		
☐	Individual has not previously received RPE65 gene therapy in intended eye		
☐	Confirmation of sufficient viable retinal cells in each eye planned for treatment by treating physician within the past 6 months. Verification must be documented and evident by **at least one** of the following: ☐ Optical coherence tomography (OCT) thickness >100um with presence of neural retina in the posterior pole ☐ > 3 disc areas of retina free of atrophy and/or pigmentary degeneration in the posterior pole ☐ Intact visual field within 30° of fixation as measured by a III4e isopter or equivalent		
☐	Injection in second eye is planned to be at least 6 days after the first eye		
☐	No history of intraocular surgery within the prior 6 months		
PHYSICIAN SIGNATURE – PROVIDER ONLY			
This form must be signed by an ophthalmologist or retinal specialist/surgeon			
☐	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:			