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

AMVUTTRA 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 consultation with a neurologist		
☐	Individual has a diagnosis of hATTR amyloidosis as documented by amyloid deposition on tissue biopsy and presence of a pathogenic TTR variant using molecular genetic testing is confirmed		
☐	Individual has mild to moderate polyneuropathy		
☐	Documentation of at least **one** of the following: ☐ Clinical signs and symptoms of peripheral neuropathy (such as tingling, or increased pain in the hands, feet and/or arms, loss of feeling in the hands and/or feet, numbness or tingling in the wrists, carpal tunnel syndrome, loss of ability to sense temperature, difficulty with fine motor skills, weakness in the legs, difficulty walking) ☐ Clinical signs and symptoms of autonomic neuropathy symptoms (such as orthostasis, abnormal sweating, dysautonomia, constipation and/or diarrhea, nausea, vomiting, anorexia and early satiety)		
☐	Other causes of the polyneuropathy have been ruled out		
☐	Individual does not have a history of liver transplant		
☐	Therapy is not being used in combination with other transthyretin (TTR) reducing agents (Ex. inotersen, tafamidis, patisiran, etc.)		
☐	Individual is ≥18 years of age		
Continuation of Therapy (check one)		**Yes** ☐	**No** ☐
☐	Individual continues to meet initial criteria		
☐	Documentation is submitted indicating improvement or stabilization in clinical signs and symptoms of disease (improvement in ambulation, neurologic symptom burden, or activities of daily living)		
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:			