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:	**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 an ophthalmologist or retinal specialist/surgeon	
☐	Individual is ≥12 months of age	
☐	Individual has a confirmed diagnosis of biallelic RPE65 mutation-associated retinal dystrophy	
☐	Documentation is submitted indicating there is sufficient viable retinal cells in each eye as evident by **at least one** of the following within the past 6 months: ☐ 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	
☐	Individual has significant vision impairment as shown by **one** of the following: ☐ Best corrected visual acuity (BCVA) of 20/60 or worse in both eyes ☐ Visual field less than 20 degrees in any meridian as measured by a III4e isopter or equivalent in both eyes	
☐	Individual has not previously received RPE65 gene therapy	
☐	Injection in second eye is planned to be within a close interval, 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:		