COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

ANTIEMETIC/ANTIVERTIGO MEDICATIONS

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name:

First Name:

Medicaid ID Number:

Date of Birth: ___ – ___ – ____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: ___ – ___ – ____

Fax Number: ___ – ___ – ____

DRUG INFORMATION

Does NOT require SA: ondansetron (ODT/tablet/solution) (maximum quantity per fill = 60 for ODT/tablet); meclizine; metoclopramide (tablet/solution); prochlorperazine (tablet/syrup); promethazine in members over 2 years of age.

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

 Revised: 10/28/2022 | Effective: 01/01/2022

Member's Last Name:

Member's First Name:

DIAGNOSIS AND MEDICAL INFORMATION

1. Does the member have a diagnosis of severe, chemotherapy-induced nausea and vomiting?
   ☐ Yes ☐ No
2. If the member's diagnosis is acquired immunodeficiency syndrome (AIDS)-related wasting, has the member tried and failed megestrol acetate oral suspension **OR** does the member have a contraindication, intolerance, or drug-drug interaction?
   ☐ Yes ☐ No
3. Does the member have nausea or vomiting related to radiation therapy, moderate to highly emetogenic chemotherapy, or post-operative nausea and vomiting?
   ☐ Yes ☐ No
4. Has the member tried and failed therapeutic doses of, or had adverse effects or contraindications to, **TWO** different conventional antiemetics (e.g., promethazine, prochlorperazine, meclizine, metoclopramide, dexamethasone)?
   ☐ Yes ☐ No
5. Does the member have hyperemesis (i.e., pregnancy-related nausea/vomiting)?
   ☐ Yes ☐ No
6. Does the member have diabetic gastroparesis? If yes, list why oral metoclopramide can not be used.
   ☐ Yes ☐ No

   _____
7. What clinical evidence can be provided that the preferred agent(s) will not provide adequate benefit, what pharmaceutical agents were attempted, and what were the outcomes?

   _____

_____ _____

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:
Magellan Medicaid Administration / ATTN: MAP
11013 W. Broad Street, Glen Allen, VA 23060