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CardinalCare
Virginia's Medicaid Program

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

ROUTINE PDL

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: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

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Member's Last Name: **Member's First Name:**

PRESCRIPTION AND MEDICAL INFORMATION

Routine PDL Criteria

(Note: Some medications have additional clinical edits that may apply. See website for criteria details.)

1. Is there any reason the member cannot be changed to a medication not requiring service authorization (SA) within the same class?

   Acceptable reasons include (Document clinically compelling information):

   ☐ Allergy to medications not requiring SA: _____

   ☐ Contraindication to medications not requiring SA: _____

   ☐ Drug-to Drug Interaction to medications not requiring SA: _____

   ☐ Unacceptable/toxic side effect to medications not requiring SA: _____

   ☐ Therapeutic failure to medications not requiring SA: _____

   ☐ Member's condition is clinically stable and changing to a medication not requiring SA may cause deterioration of the member's condition: _____

   ☐ Other clinical justification to support use of the requested medication:

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:
Prime Therapeutics Management, LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811