



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:

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First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Medicaid ID Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Birth:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Gender: Male Female

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

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First Name:

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NPI Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Fax Number:

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DRUG INFORMATION

Preferred PPIs: Omeprazole Rx and Pantoprazole (no SA required for short-term use; less than 90 days). All PPIs (preferred and non-preferred) after 90 days of utilization MUST meet the clinical service authorization criteria for continued use.

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name:

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Member's First Name:

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DIAGNOSIS AND MEDICAL INFORMATION

1. Request type.

Initial Renewal

Note: PDL criteria must be met first before a non-preferred PPI may be approved. *Initial requests* may be authorized for **12 weeks only**. *Renewal requests for both preferred and non-preferred PPI usage for greater than 3 months* may be allowed for 1 year **ONLY** if one of the following exceptions has been met: Member is under the care of a Gastroenterologist OR member has a diagnosis of ACTIVE GI Bleed, Erosive Esophagitis, Gastroesophageal Reflux Disease, Pathological Hypersecretory Syndrome, Unhealed Gastric, Duodenal or Peptic Ulcer, Barrett's Esophagus or Zollinger-Ellison Syndrome.

2. Has the member had a therapeutic failure of no less than a 3-month trial of at least TWO preferred PPIs?

Yes No

a. If YES, list medications:

Drug 1: _____ Strength: _____ Start Date: _____

Drug 2: _____ Strength: _____ Start Date: _____

Drug 3: _____ Strength: _____ Start Date: _____

b. If NO, document compelling details: _____

3. Has this member seen a Gastroenterologist?

Yes No *If YES, document name:* _____

4. Does this member have one of the following conditions?

- a. GI Bleeds Yes No
- b. Zollinger-Ellison Syndrome Yes No
- c. Gastroesophageal Reflux Disease Yes No
- d. Pathological Hypersecretory Syndrome Yes No
- e. Unhealed Gastric, Duodenal or Peptic Ulcer Yes No
- f. Barrett's Esophagus Yes No
- g. Erosive Esophagitis Yes No

5. **Medical Necessity** (Provide clinical evidence that the preferred agent(s) will not provide adequate benefit):

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