VIRGINIA MEDICAID REQUEST FOR DRUG SERVICE AUTHORIZATION

COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

Requests for service authorization (SA) must include patient name, Medicaid ID#, and drug name. Appropriate clinical information to support the request on the basis of medical necessity must be submitted. 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 AND FINAL COVERAGE DECISIONS MAY BE AFFECTED BY SPECIFIC MEDICAID LIMITATIONS.**

The completed form may be **FAXED TO 800-932-6651.** Requests may be phoned to 800-932-6648.

Requests may be mailed to: Provider Synergies, an affiliate of Magellan Medicaid Administration / 11013 W. Broad St / Glen Allen, VA 23060 / ATTN: MAP

Today's Date: ___ ___/___ ___/___ ___ ___ ___ Requested Start Date: ___ ___/___ ___/___ ___ ___ ___

PATIENT INFORMATION

Name: (Last, First) _____ **Medicaid ID#:** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ __

Date of Birth: ___ ___/___ ___/___ ___ ___ ___ **Gender:** □ **Male** □ **Female**

DRUG INFORMATION

Drug Name/ Form: _____ **Diagnosis:** _____

Strength/Dose Frequency: _____ **Length of Therapy:** _____

PRESCRIPTION/MEDICAL HISTORY Please Answer All Questions to Facilitate Processing

Routine PDL Criteria (Note – Some medications have additional clinical edits that may apply. See website for criteria details.)

Is there any reason the patient 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: _____

□ Patient's condition is clinically stable and changing to a medication not requiring SA may cause deterioration of the patient's condition: _____

_____

□ Other clinical rationale to support use of the requested medication: _____

_____

_____

PRESCRIBER INFORMATION

Name (print):_____ **NPI Number:** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Phone Number: (___ ___ ___) ___ ___ ___-___ ___ ___ ___ **Fax Number:** (___ ___ ___) ___ ___ ___-___ ___ ___ ___

Signature of Prescribing Provider: _____

PLEASE INCLUDE ALL REQUESTED INFORMATION

INCOMPLETE FORMS WILL DELAY THE SERVICE AUTHORIZATION PROCESS

FAX TO 800-932-6651

SERVICE AUTHORIZATION CRITERIA IS SUBJECT TO CHANGE AND THUS DRUG COVERAGE