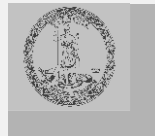


VIRGINIA MEDICAID REQUEST FOR DRUG SERVICE AUTHORIZATION



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

<http://www.virginiamedicaidpharmacyservices.com>