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CardinalCare
Virginia's Medicaid Program

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

Non-Preferred Incretin Mimetics

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

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

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

DIAGNOSIS AND MEDICAL INFORMATION

All drugs in this class are eligible to receive a twelve (12)-month approval. Complete the following questions:

1. Does the member have a diagnosis of type 2 diabetes mellitus?

   ☐ Yes ☐ No

   If **Yes**, please provide the value of the lab that was performed within the last 12 months and has been used to confirm the member's diagnosis, along with the date of the result (A1c of greater than or equal to 6.5 is required for first starts):

   ☐ **A1c** Value: _____ Date: _____

2. Has the member tried and failed an adequate trial of 2 different preferred products?

   ☐ Yes ☐ No

   If **Yes**, please specify the drug, the length of the member's trial, and reason for discontinuation.

   Drug 1: _____

   Length of Trial: _____ Reason for Discontinuation: _____

   Drug 2: _____

   Length of Trial: _____ Reason for Discontinuation: _____

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