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CardinalCare
Virginia's Medicaid Program

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

PROTON PUMP INHIBITORS (PPIs)

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

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: **Member's First Name:**

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