Virginia Medicaid
DOSE OPTIMIZATION
Service Authorization Request Form

The intent of this initiative is to use the optimum dose of a product to fill a prescription. An example of this is to use one 10 mg Abilify® tablet instead of two 5mg Abilify® tablets to fill a prescription. If the quantity submitted on the claim exceeds the allowable units for a 34-day supply then the claim will reject with an error message of *"Quantity Exceeds Maximum of 34 - Physician Call 1-800-774-8481"*. In order for patients to receive more than a 34-day supply for these drugs, it will be necessary for the prescriber to complete and fax or mail this service authorization (SA) request to Magellan Medicaid Administration.

Use this form to request service authorization for medications that are part of the Dose Optimization initiative.
The full list of medications restricted to the dose optimization initiative can be found on page 2.

Prescribing Physician:
Name: ___________________________________

Phone #__________________________________

Fax #: ___________________________________

Pharmacy (if known):________________________

Patient:
Name: ____________________________________

Medicaid ID #:_____________________________

Date of Birth: ____________ Sex: ___________

Phone: ______________&/or FAX:___________

Drug Requested: ____________________ Strength & Frequency: _____________ Length of therapy:

Please answer the following questions, as applicable, to obtain an approval for a SA:

1. Has the patient tried less frequent dosing but was not able to tolerate due to adverse effects? If so, list the dose attempted and the failure.____
2. Does the patient dose require a quantity greater than 34 and this is the only way for the patient to get the prescribed daily dose? (i.e., Abilify® 4 mg daily – patient would need two (2) x 2 mg tablets). Please list the dose.____
3. The patient has a specific indication that requires higher than normal dosing. Please list the specific indications.____
4. Does the patient require 1 and ½ tablets (instead of using 2 different strengths)? Yes or No
5. Is the patient dose in the process of being titrated? If so, please give the timeframe that the titration is expected to last.____
6. Is the patient receiving Risperdal® for Schizophrenia? If so, please indicate. ___________________
7. Please indicate other reason(s) why a SA is requested. ______________________________________

Comments:

Prescriber Signature: ____________________________________ Date of this request: ____________

- Once this Fax form is received by Magellan Medicaid Administration a response will be sent to the requesting physician within 24 hours.
- 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.
- This form should be used only for Dose Optimization request and cannot be used for SA requests for any other programs such as weight loss drugs, step edit or PDL.

Brand Name	Generic Name	Limitations
Abilify® 2 mg, 5 mg, 10 mg, 15 mg, 20 mg	aripiprazole	1 tablet /daily
Aciphex® 20 mg	rabeprazole sodium	2 tablets /daily
Adderall® XR 5 mg, 10 mg, 15 mg	amphetamine; dextroamphetamine	1 capsule /daily
Adderall® XR 20 mg, 25 mg, 30 mg		2 capsules /daily
Avinza® 30 mg, 60 mg, 90 mg, 120 mg	morphine sulfate ER	1 capsule /daily
Byetta®	exenatide	1 pen/28d
Concerta® 18 mg, 27 mg, 54 mg	methylphenidate	1 tablet /daily
Concerta® 36 mg	methylphenidate	2 tablets /daily
Daytrana® 10 mg, 15 mg, 20 mg, 30 mg patches	methylphenidate	1 patch/ daily
Effexor® XR. 37.5 mg, 75 mg	venlafaxine HCL ER	1 capsule/daily
Elidel® cream	pimecrolimus	30 grams/month
Enbrel® 25 mg, 50 mg	etanercept	8 units/ month
Focalin® XR 5 mg, 10 mg, 15 mg, 20 mg, 25mg , 30 mg , 35mg	dexmethylphenidate	1 capsule/daily
Janumet® 50/500 mg, 50/1000 mg	metformin & sitagliptin	2 tablets /daily
Januvia® 25 mg, 50 mg, 100 mg	sitagliptin	1 tablet /daily
Kadian® 10, 20, 30, 50, 60, 80, 100, 200 mg	morphine sulfate ER	2 tablets /daily
Lexapro® 5 mg, 10 mg	escitalopram	1 tablet /daily
Metadate® CD 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg	methylphenidate ER	1 capsule/daily
Nexium® 10 mg, 20 mg, 40 mg	esomeprazole	2 capsules/daily
OxyContin® 10 mg, 15 mg, 20 mg, 30 mg, 40 mg , 60 mg, 80mg	oxycodone	3 tablets /daily
Prevacid® 15 mg, 30 mg caps, disint. tabs	lansoprazole	2 capsules/daily
Prilosec® OTC 20 mg	omeprazole	4 tablets /daily
Protonix® 20 mg, 40 mg	pantoprazole	2 tablets /daily
Protopic® ointment	tacrolimus	30 grams/month
Provigil® 100 mg, 200 mg	modafinil	1 tablet /daily
Ritalin® LA 10 mg, 20 mg, 30 mg, 40 mg	methylphenidate HCL ER	1 capsule/daily
Risperdal® 0.25 mg, 0.5 mg, 1 mg, 2 mg	risperidone	1 tablet /daily
Seroquel® XR 150 mg, 200 mg	quetiapine fumarate ER	1 tablet /daily
Strattera® 10 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg, 100 mg	atomoxetine	1 tablet /daily
Victoza®	liraglutide	1 pkg/28d
Vyvanse® 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 70 mg	lisdexamfetamine	1 capsule/daily
Zyprexa® 2.5 mg, 5 mg, 7.5 mg, 10 mg	olanzapine	1 tablet /daily
Zyprexa® Zydis 5 mg, 10 mg	olanzapine	1 tablet /daily

Submit requests via phone, fax or mail to:

Magellan Medicaid Administration
MAP Department
11013 W. Broad Street
Glen Allen, VA 23060

Tel: 1-800-932-6648
Fax: 1-800-932-6651

For Magellan Medicaid Administration Use Only

Comments: ____

Approved Changed Denied Pending

MAP RPh/Tech: ____

NDC: ____

Date of Decisions: ____