



**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, 30 mg | 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® Zydys 5 mg, 10 mg | olanzapine | 1 tablet /daily |

Submit requests via phone, fax or mail to: **Magellan Medicaid Administration** **Tel: 1-800-932-6648**
MAP Department **Fax: 1-800-932-6651**
4300 Cox Road
Glen Allen, VA 23060

| For Magellan Medicaid Administration Use Only | | | |
|---|---------|--------|---------|
| Comments: | _____ | _____ | _____ |
| Approved | Changed | Denied | Pending |
| MAP RPh/Tech: | _____ | _____ | _____ |
| NDC: | _____ | _____ | _____ |
| Date of Decisions: | _____ | _____ | _____ |