

MOLINA HEALTHCARE 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:													
MOLINA 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 OTC and Rx, Pantoprazol	le tablet, Protonix suspension (no SA required for short-													
• • •	non-preferred) after 90 days' utilization MUST meet the													
clinical service authorization criteria for continued us	e.													
Drug Name/Form:														
Strength:														
Dosing Frequency:														
Length of Therapy:														
Quantity per Day:														
(Form continued on next page.)														

Page 1 of 2

Molina SA Form: Proton Pump Inhibitors (PPIs)

Member's Last Name:												Member's First Name:															
			C A	ND	D 41			1815	·	447	1001												1	1			
	AGNO				IVII	וטו	CAL	IINF	OKI	VIA I	ION																
1.	Requ		-	. —	٦,		1																				
			al	_	_		ewal	m	o+ fi	rct h	ofor		a n	nr	ofor	rod	ומם	ma	v ho	200	rov	.	Initi	al ro	auac	sts ma	ny ho
														•					-						•		eater
								-			•		-								-					Mem	
						•				•	ist O								_	•							
										_							_									Gast	ric,
	•		_				•	_			opha				_					-	•		,				,
2.	Y	⁄es			N	lo			euti	c fai	lure (of no	les	ss t	han	a 3	-mo	onth	tria	l of a	at lea	ast	TWO) pre	eferr	ed PF	ls?
	a.		•				catio						۵.								٥.						
	Drug 1: S																										
		Drug 2: S																									
			nt compelling details:														Start Date:										
	D.	"	IVO,	uoc	Juii	icii	t coi	прс	·······8	ucti																	
3.		this es	s me	emb	er s						logist																
4.	Does	s th	is n	nem	bei	r ha	ave c	ne d	of the	e fol	lowin	g co	ndi	tio	ns?												
	a.	G	Ble	eds											Ye	es			No)							
	b.			_			า Syn								Ye	es			No)							
	c.				•	_	eal R								Y	es			No)							
				_		•	•		•	•	drom			L	=	es			_ No								
	e. Unhealed Gastric, Duodenal or Pe	eptic	Ulce	er	L	Yes				☐ No																	
						•	agus							L	=	es		Ļ	_ No								
	g.	Er	osiv	e Es	sop	ha	gitis								Y	es			_ No)							
5.	Med	lica	l Ne	eces	sity	/: P	rovi	le cl	inica	ıl evi	idenc	e tha	it t	he	pre	ferre	ed a	ager	nt(s)	will	not _l	pro	vide	ade	quat	e bei	nefit:
Pre	escrib	oer	Sig	natu	ire	(Re	quir	ed)													Da	te					
-	signa d veri				-					:he a	bove	info	rm	ati	on i	s ac	cur	ate									
				•							•		1_1							
						•					n; inc	-						-			-	ess	.				
Sur	SSIITIU	ion	OT (JOCU	ıme	enta	auon	uoe	:S IN(וע gl	uaran	tee c	.OV6	era	ige t	yν	IOII	na F	ieait	ncar	e.						
The	com	nple	etec	l for	m r	may	y be	FAX	ED t	ა 1-8	344-2	78-5	73:	1 , c	or yo	ou m	nay	call	(800) 42	4-45	18	(TT)	′: 71	.1).		

© 2022 Molina Healthcare, Inc. All Rights Reserved. Revision Date: 12/20/2021 Effective Date: 01/01/2022

Page 2 of 2