MOLINA HEALTHCARE

Molina Complete Care

MOLINA COMPLETE CARE
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: | | | | | | | | | | | | |

MCC 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, Pantoprazole tablet, Protonix suspension (no SA required for short-term use; less than 90 days). All PPIs (preferred and non-preferred) after 90 days' 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.)

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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 Molina Complete Care.

The completed form may be **FAXED to 1-844-278-5731**, or you may call the number below.

CCC Plus: 1-800-424-4524 (TTY 711)
Medallion 4.0: 1-800-424-4518 (TTY 711)

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