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: – –

Weight in Kilograms: ____________________________

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: – –

Fax Number: – –

DRUG INFORMATION

For initial requests, continue below. For renewal requests, proceed to page 3 of this form. If approved, initial authorizations are granted for 6 months. Renewal authorizations are granted for 12 months.

Drug Name: ______________________________________ **Drug Form:** __________________________________

Drug Strength: ____________________________________ **Dosing Frequency:** ___________________________

Length of Therapy: _________________________________ **Quantity:** ___________________________________

Day Supply: _______________________________________

- **FDA indicated medications only**
- **Must be prescribed by a cardiologist or vascular specialist for the member to receive authorization.**

Please include ALL requested information and answer ALL questions on the following pages of this form. Incomplete forms will delay the SA process. If the provider is unable to attest to ALL of the following, a denial of coverage will be rendered.

(Form continued on next page.)

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Member's Last Name: | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | |

DRUG SPECIFIC CRITERIA

☐ The member 45 years of age or older; **AND**

☐ The medication is prescribed by a cardiologist or vascular specialist; **AND**

☐ The member has a clinical history of one of the following: **AND**

- ☐ Myocardial infarction (MI) defined as cardiac biomarkers, an electrocardiogram or cardiac imaging; **OR**
- ☐ Stroke defined as neurological dysfunction as a result of a hemorrhage or infarction**; OR**
- ☐ Peripheral artery disease as defined by intermittent claudication with ankle-brachial index less than 0.85 at rest, or peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease

☐The member has not had a MI, stroke, transient ischemic attack or hospitalization for unstable angina in the last 60 days **AND**

☐ The member has a BMI ≥ 27 kg/m^2; **AND**

☐ The provider attests that the member received individualized healthy lifestyle counseling; **AND**

☐The member does not have a previous diagnosis of diabetes; **AND**

☐The member does not have pancreatitis, acute suicidal behavior/ideation, personal or family history of medullary thyroid cancer or multiple endocrine neoplasia 2 syndrome

☐ Check if additional documents will be uploaded

(Form continued on next page.)

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Member's Last Name: | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | |

LENGTH OF AUTHORIZATION

Renewal Request: See additional requirements below:

☐ The member continues to meet the criteria

☐ The member is being treated with a maintenance dosage of the requested drug

____ ____________________

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information and answer ALL questions. Incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by Molina Healthcare.

The completed form may be: FAXED to **(844) 278-5731,** or you may call **(800) 424-4518 (TTY: 711).**

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