



Prior Authorization Form
PROTON PUMP INHIBITORS

ONLY COMPLETED REQUESTS WILL BE REVIEWED

- Drug Requested: (check one)
- | | | | |
|--|------------------------------------|---|---|
| <input type="checkbox"/> Protonix suspension | <input type="checkbox"/> Prevacid® | <input type="checkbox"/> Aciphex® | <input type="checkbox"/> Protonix® |
| <input type="checkbox"/> Prevacid® solutabs | <input type="checkbox"/> Vimovo® | <input type="checkbox"/> Pylera® | <input type="checkbox"/> Dexilant® |
| | <input type="checkbox"/> Zegerid® | <input type="checkbox"/> Prilosec® suspension | <input type="checkbox"/> Zegerid® packets |

Date: _____ Patient ID#: _____ DOB: _____
 Patient Name: _____ Provider NPI: _____
 Prescribing Physician: _____ Office Contact: _____
 Office Fax #: _____ Office Phone: _____

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. DIAGNOSIS FOR DRUG REQUESTED (request will not be processed without diagnosis)

- GERD Gastric Ulcer or PUD Other (specify) _____

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

N/A If none or not applicable to diagnosis, indicate "N/A."

Drug Name	Date	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. PATIENT HISTORY

- a. Has the patient tried and failed prescription generic omeprazole , pantoprazole or lansoprazole for at least 14 days?(*specify in section above*) Yes No
- b. Has the patient tried any Esomeprazole (Nexium®) containing products? Yes No
- c. Does the patient have an inability to swallow capsules/tablets because of (dysphagia, GI tubes, etc.)? Yes No

Please add any other supporting medical information that may be useful in the decision-making process including contraindications to the medications related to the diagnosis:

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.