



Prior Authorization Form
PROTON PUMP INHIBITORS

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: (check one) [] Prevacid [] Nexium [] Nexium suspension [] Aciphex [] Protonix [] Prevacid NapraPAC [] Pylera [] Kapidex [] Prevacid solutabs [] Zegerid [] Prilosec suspension [] 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."

Table with 3 columns: Drug Name, Date, Duration. Includes three rows of blank lines for data entry.

- 3. PATIENT HISTORY
a. Has the patient tried and failed prescription generic omeprazole, pantoprazole or lansoprazole for at least 14 days?
b. Has the patient tried any Esomeprazole (Nexium) containing products?
c. Does the patient have a history of gastric ulcer? (NapraPAC only)
d. Does the patient have an inability to swallow capsules/tablets because of (dysphagia, GI tubes, etc.)?

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.