



Prior Authorization Form
Proton Pump Inhibitors and Pylera

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: (check one) [] Prevacid [] Nexium [] Nexium suspension [] Aciphex [] Protonix
[] Prevacid NapraPAC (lansoprazole/naproxen) [] Pylera
[] Prevacid solutabs or suspension [] Zegerid

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

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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 for listing medication history.

3. PATIENT HISTORY

- a. Has the patient tried and failed prescription generic omeprazole or pantoprazole for at least 14 days? [] Yes [] No
b. Does the patient have a history of intolerance/allergy/contraindication to omeprazole, pantoprazole, Prevacid or Nexium? (specify): [] Yes [] No
c. Has the patient tried any Esomeprazole (Nexium) containing products? [] Yes [] No
d. Has the patient tried any Lansoprazole (Prevacid) containing products? [] Yes [] No
e. Does the patient have a history of gastric ulcer? (NapraPAC only) [] Yes [] No [] N/A
f. 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:

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

Internal use only
Document #
Coverage effective date / /
Processor Initials Date
M F Rx coverage Y N STANDARD - SELECT LOB
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