Please complete ALL information below and fax your request to 1-888-671-5285

Proton Pump Inhibitors Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

- ❑ Barrett's esophagus
- ❑ Duodenal ulcer
- ❑ Erosive esophagitis
- ❑ Gastric ulcer
- ❑ Gastrointestinal bleed
- ❑ Other diagnosis: ____________________________
- ❑ Gastroesophageal reflux disease (GERD)
- ❑ Helicobacter pylori gastrointestinal tract infection
- ❑ Non-steroidal anti-inflammatory drug (NSAID) gastropathy
- ❑ Pathological hypersecretory conditions including Zollinger-Ellison Syndrome
- ❑ Ulcerative esophagitis

ICD-10 Code(s): ___________________________________

Select the medication(s) the patient has trial and failure or intolerance to:

- ❑ Dexilant
- ❑ Esomeprazole
- ❑ Lansoprazole capsule
- ❑ Omeprazole
- ❑ Pantoprazole
- ❑ Rabeprazole tablet

Quantity limit requests:

What is the quantity requested per day? ________

Has the patient had a trial and an inadequate response to once-daily proton pump inhibitor (PPI) regimen? ❑ **Yes** ❑ **No**

Is a once-daily PPI regimen NOT appropriate to treat the patient's condition? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.

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