



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:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Barrett's esophagitis	<input type="checkbox"/> Laryngopharyngeal reflux
<input type="checkbox"/> Erosive esophagitis	<input type="checkbox"/> Pathological hypersecretory condition including Zollinger-Ellison syndrome
<input type="checkbox"/> Gastric ulcer	<input type="checkbox"/> Peptic ulcer disease (PUD)
<input type="checkbox"/> Gastroesophageal reflux disease (GERD)	<input type="checkbox"/> Risk reduction nonsteroidal anti-inflammatory drugs (NSAIDs) associated gastric ulcer
<input type="checkbox"/> GERD with nocturnal symptoms	<input type="checkbox"/> Upper gastrointestinal bleed (gastric or duodenal)
<input type="checkbox"/> Helicobacter pylori eradication	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
Select the medications the patient has had an inadequate response to a <u>two-week</u> trial of or inability to tolerate:	
<input type="checkbox"/> Lansoprazole	
<input type="checkbox"/> Omeprazole	
<input type="checkbox"/> Pantoprazole	
<input type="checkbox"/> Rabeprazole	
For formulations other than capsules or tablets (e.g. Prevacid Solutab, Aciphex Sprinkles, Zegerid packet, Prilosec granules for suspension, Protonix packets and Nexium packets), please answer the following:	
Will the drug be administered via nasogastric or gastrostomy tube? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the patient unable to swallow an intact capsule or tablet? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Quantity limit requests:	
What is the quantity requested per DAY? _____	
Has the patient failed once daily proton pump inhibitor therapy? <input type="checkbox"/> Yes <input type="checkbox"/> 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?

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

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