FUTURE SCRIPTS

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	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Barrett's esophagitis
- ❑ Erosive esophagitis
- ❑ Gastric ulcer
- ❑ Gastroesophageal reflux disease (GERD)
- ❑ GERD with nocturnal symptoms
- ❑ Helicobacter pylori eradication
- ❑ Laryngopharyngeal reflux
- ❑ Pathological hypersecretory condition including Zollinger-Ellison syndrome
- ❑ Peptic ulcer disease (PUD)
- ❑ Risk reduction nonsteroidal anti-inflammatory drugs (NSAIDs) associated gastric ulcer
- ❑ Upper gastrointestinal bleed (gastric or duodenal)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Select the medications the patient has had an inadequate response to a two-week trial of or inability to tolerate:

- ❑ Lansoprazole
- ❑ Omeprazole
- ❑ Pantoprazole
- ❑ 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? ❑ **Yes** ❑ **No**

Is the patient unable to swallow an intact capsule or tablet? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

Has the patient failed once daily proton pump inhibitor therapy? ❑ **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?

_____

_____

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