Proton Pump Inhibitors Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-512-9004.
Provider Help Desk: 800-454-3730

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization (PA) is not required for the preferred proton pump inhibitors (PPI) for doses within the established quantity limits of one unit per day. Payment for a nonpreferred PPI will be authorized only for cases in which there is documentation of previous trials and therapy failures with three preferred agents.

Preferred

- ☐ Dexilant
- ☐ Omeprazole Caps (Rx)
- ☐ Pantoprazole

Nonpreferred (PA required)

- ☐ Aciphex
- ☐ Esomeprazole
- ☐ Lansoprazole
- ☐ Naproxen/Esomeprazole
- ☐ Nexium Caps
- ☐ Omeprazole/Sodium Bicarb (Rx)
- ☐ Prevacid
- ☐ Prilosec (Rx)
- ☐ Rabeprazole
- ☐ Vimovo

Diagnosis:

- ☐ Barrett's esophagus (Please fax a copy of the scope results with the initial request.)
- ☐ Erosive esophagitis (Please fax a copy of the scope results with the initial request.)
- ☐ Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis and multiple endocrine adenomas)
- ☐ Recurrent peptic ulcer disease
- ☐ Symptomatic gastroesophageal reflux.Requests for PPIs exceeding one unit per day will be considered after documentation of a therapeutic trial and therapy failure with concomitant use of once daily PPI dosing

and a bedtime dose of a histamine H2-receptor antagonist. Upon failure of the combination therapy, subsequent requests for PPIs exceeding one unit per day will be considered on a short term basis (up to 3 months). After the three month period, a retrial of the recommended once daily dosing will be required. A trial of the recommended once daily dosing will be required on an annual basis for those patients continuing to need doses beyond one unit per day.

☐ Active helicobacter pylori infection (attach documentation).rRequests for twice daily dosing will be considered for up to 14 days of treatment for an active infection
☐ Other: _____

Trial medications and dates: _____
_____

Medical or contraindication reason to override trial requirements: _____

Scope performed? ☐ No ☐ Yes
If yes, date of scope: _____
Reason for use of nonpreferred drug requiring prior approval: _____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____
Prescriber or authorized signature Date
***** Must match prescriber listed above

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Important note*: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*