

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Proton Pump Inhibitors
 Complete form in its entirety and fax to:
 Prior Authorization of Benefits (PAB) Center at (866) 807- 6241

1. PATIENT INFORMATION
2. PHYSICIAN INFORMATION

Patient Name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient Phone #: _____ Patient Email Address: _____	Prescribing Physician: _____ Physician Address: _____ Physician Phone #: _____ Physician Fax #: _____ Physician Specialty: _____ Gastroenterologist <input type="checkbox"/> Yes <input type="checkbox"/> No Other Specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician Email Address: _____
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3. MEDICATION
4. STRENGTH
5. MEDICATION
6. STRENGTH

Preferred PPIs: <input type="checkbox"/> Generic omeprazole <input type="checkbox"/> OTC - omeprazole Preferred Brand PPIs: <input type="checkbox"/> Prevacid/Prevacid SoluTab/ Prevacid Suspension (lansoprazole)	<input type="checkbox"/> 10mg <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg <input type="checkbox"/> 20mg <input type="checkbox"/> 15mg <input type="checkbox"/> 30mg	Non-Preferred PPIs: <input type="checkbox"/> AcipHex (rabeprazole) <input type="checkbox"/> Kapidex (dexlansoprazole) <input type="checkbox"/> Nexium (esomeprazole) <input type="checkbox"/> pantoprazole <input type="checkbox"/> Prilosec (omeprazole) <input type="checkbox"/> Prilosec Oral Suspension (omeprazole magnesium) <input type="checkbox"/> Protonix (pantoprazole) <input type="checkbox"/> Protonix Oral Suspension (Pantoprazole) <input type="checkbox"/> Zegerid (omeprazole/sodium bicarbonate)	<input type="checkbox"/> 20mg <input type="checkbox"/> 30mg <input type="checkbox"/> 60mg <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg <input type="checkbox"/> 10mg <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg <input type="checkbox"/> 2.5mg <input type="checkbox"/> 10mg <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg <input type="checkbox"/> 40mg <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg
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7. DIRECTIONS
8. QUANTITY per 30 days

_____ _____	Specify: _____
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9. DIAGNOSIS

_____ <p><i>If criteria is met AND the patient has Structural GERD (erosive esophagitis, Barrett's Esophagus, esophageal strictures, acid-induced asthma, scleroderma related symptoms) or Hypersecretory Condition (Zollinger-Ellison, multiple endocrine adenomas, or systemic mastocytosis) the medication will be approved for 1 year</i></p>
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10. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request

For Preferred Brand PPIs and/or Non Preferred PPIs – Please include documentation with the following information (excluding samples)				
DRUG NAME	DOSE	SIG	TRIAL DATE(s)	TRIAL DURATION
1.				
2.				
For Preferred Brand PPIs (Prevacid, Prevacid SoluTab, Prevacid Suspension): <input type="checkbox"/> Yes <input type="checkbox"/> No Patient has tried and failed OTC omeprazole (20mg tablets) or prescription omeprazole (10, 20mg Capsules, 40mg tablets) in the previous 180 days <input type="checkbox"/> Yes <input type="checkbox"/> No Patient is under 12 years of age who has difficulty with swallowing an intact capsule <input type="checkbox"/> Yes <input type="checkbox"/> No Patient is currently being treated with requested preferred brand PPI agent				
For Non-Preferred PPIs (Aciphex, Kapidex, Nexium, Nexium Suspension, pantoprazole, Protonix, Protonix Oral Suspension, Prilosec, Prilosec Oral Suspension, and Zegerid): <input type="checkbox"/> Yes <input type="checkbox"/> No Patient has tried and failed two (2) of the following preferred PPI's within the past 180 days: <input type="checkbox"/> omeprazole (OTC or prescription 10 or 20mg, 40mg tablets) <input type="checkbox"/> Prevacid/Prevacid SoluTab/ Prevacid Suspension				
Quantity Limits: For omeprazole 20mg, coverage is limited to 60 doses every 30 days. All other proton pump inhibitors are limited to 30 doses every 30 days. Requests for increased quantity please answer the following: Increased Dosing up to 2 doses/day may be approved if the following apply: <input type="checkbox"/> Yes <input type="checkbox"/> No Did the patient respond after a 30-day trial of once daily dosing of the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No The patient is currently on a preferred agent (omeprazole) at a dose of 2 per day. <input type="checkbox"/> Yes <input type="checkbox"/> No The patient is currently on a preferred <u>brand</u> agent (Prevacid, Prevacid SoluTab, Prevacid Suspension) at a dose of 2 per day. Increased Dosing beyond 2 doses/day may be approved if the following diagnosis apply: <input type="checkbox"/> Yes <input type="checkbox"/> No Hypersecretory syndrome (Zollinger-Ellison syndrome, multiple endocrine adenomas, or systemic mastocytosis) <input type="checkbox"/> Yes <input type="checkbox"/> No Laryngeal, esophageal or gastric cancer				

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11. PHYSICIAN SIGNATURE

_____ Prescriber or Authorized Signature	_____ Date
<i>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.</i>	
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.	
IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is STRICTLY PROHIBITED . If you have received this message by error, please notify us immediately at (800) 338-6180 and destroy the related message or return the document to us at 8407 Fallbrook Avenue AF13, West Hills, CA 91304. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without appropriate patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law.	

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