PRIOR AUTHORIZATION REQUEST

PPI Quantity Limit

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Does the patient have a previously approved prior authorization (PA) for the requested medication on file in the last year from MPC? [If no, skip to question 3.]	Yes	No
2	Is the patient responding to therapy? [No further questions.]	Yes	No
3	What is the diagnosis or indication? [] Barrett's esophagus (If checked, go to 4)		

If you have any questions, call: 1-888-258-8250

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[] Erosive esophagitis (If checked, go to 4)

[] Zollinger-Ellison syndrome (If checked, go to 4)

[] Recurrent peptic ulcer disease (If checked, go to 4)

[] Other hypersecretory condition (If checked, go to 4)

[] Gastroesophageal reflux disease (If checked, go to 5)

[] Other indication (If checked, go to 6)

4	Has the patient experienced breakthrough symptoms on once daily dosing of a Proton pump inhibitor (PPI)? [No further questions.]	Yes	No
5	Has the patient been on a Proton pump inhibitor (PPI) for at least 3 months and is experiencing breakthrough symptoms on once daily dosing? [No further questions.]	Yes	No
6	Is the requested medication being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? [If no, no further questions.]	Yes	No
7	Has the patient been on a Proton pump inhibitor (PPI) for at least 3 months and is experiencing breakthrough symptoms on once daily dosing?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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