PRIOR AUTHORIZATION REQUEST

PROTON PUMP INHIBITORS

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 Is this request for INITIAL or CONTINUATION of therapy?

[] Initial (If checked, go to 9)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 9.]

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3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 9.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 9.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 9.]	Yes	No
6	Does the requested quantity exceed 30 capsules/tablets per 30 days (once daily dosing)? [If no, skip to question 8.]	Yes	No
7	Does the patient have a previously approved prior authorization (PA) on file for the requested quantity? [If no, skip to question 14.]	Yes	No
8	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
9	What is the requested proton pump inhibitor? [] Preferred proton pump inhibitors: A) Omeprazole over the counter (OTC), B) Lansoprazole over the counter (OTC), or C) Esomeprazole over the counter (OTC) (If checked, go to 13) [] Preferred oral disintegrating, packet, or sprinkle proton pump inhibitor (e.g., omeprazole oral disintegrating tablet) (If checked, go to 11) [] Non-preferred oral disintegrating, packet, or sprinkle proton pump inhibitor (If checked, go to 12) [] Non-preferred proton pump inhibitor (If checked, go to 10)		
10	Has the patient tried and failed at least TWO of the following formulary proton pump inhibitors (PPIs): A) Omeprazole over the counter (OTC), B) Lansoprazole over the counter (OTC), or C) Esomeprazole over the counter (OTC)? [If yes, skip to question 13.] [If no, no further questions.]	Yes	No
11	Is the patient unable to swallow capsules/tablets OR is using a feeding tube to take medications? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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	[If yes, skip to question 13.] [If no, no further questions.]		
12	Does the patient have documentation of a trial and failure, or has an intolerance or contraindication to the preferred formulary alternative omeprazole ODT? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	Does the requested quantity exceed 30 capsules/tablets/packets/sprinkles/oral disintegrating tablets per 30 days (once daily dosing)? [If no, no further questions.]	Yes	No
14	What is the diagnosis or indication? [] Barrett's esophagus (If checked, go to 15) [] Erosive esophagitis (If checked, go to 15) [] Zollinger-Ellison syndrome (If checked, go to 15) [] Recurrent peptic ulcer disease (If checked, go to 15) [] Other hypersecretory condition (If checked, go to 15) [] Gastroesophageal reflux disease (If checked, go to 15) [] Other indication (If checked, go to 16)		
15	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
16	Is the requested medication being used for a Food and Drug Administration (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
17	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:

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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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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