FAX Completed Form To
1.877.386.4695

Provider Help Desk
1.866.399.0928

Request for Prior Authorization
PROTON PUMP INHIBITORS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must fill all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization 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 non-preferred 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

Non-Preferred (PA required)
- ☐ Aciphex
- ☐ Esomeprazole
- ☐ Lansoprazole
- ☐ Naproxen/Esomeprazole
- ☐ Nexium
- ☐ Omeprazole/Sodium Bicarb (RX)
- ☐ Prevacid
- ☐ Prilosec (RX)
- ☐ Protonix
- ☐ Rabeprazole
- ☐ Vimovo

Strength _____ **Dosage Instructions** _____ **Quantity** _____ **Days Supply** _____

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). Requests for twice daily dosing will be considered for up to 14 days of treatment for an active infection.**
- ❑ **Other:**_____

Trial Medications & Dates:_____

_____

Medical or contraindication reason to override trial requirements: _____

Scope Performed? ❑ No ❑ Yes If yes, date of scope: _____

Reason for use of Non-Preferred drug requiring prior approval: _____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____

***MUST MATCH PRESCRIBER LISTED ABOVE**

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.

Rev. 10/20