Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

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 (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 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

- ☐ Esomeprazole Mag Caps
- ☐ Lansoprazole Caps
- ☐ Omeprazole Caps (RX)
- ☐ Nexium Packet
- ☐ Pantoprazole Tabs
- ☐ Protonix Packet
- ☐ Rabeprazole Tabs

Non-Preferred (PA required)

- ☐ Aciphex
- ☐ Dexilant
- ☐ Dexlansoprazole
- ☐ Esomeprazole Packet
- ☐ Konvomep
- ☐ Lansoprazole SoluTab
- ☐ Naproxen/Esomeprazole
- ☐ Nexium Caps
- ☐ Omeprazole Sod Bicarb (RX)
- ☐ Pantoprazozole Packet
- ☐ Prevacid
- ☐ Prilosec (RX)
- ☐ Protonix
- ☐ Rabeprazole Caps
- ☐ Vimovo

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

Diagnosis:

- ❑ **Barrett's esophagus, Erosive esophagitis, or Peptic stricture *(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**
- ❑ **Gastroesophageal reflux disease will be considered after documentation of a therapeutic trial and therapy failure with the requested PPI at maximal dose within the established quantity limit of one unit per day. 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 dose reduction to 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:**_____

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Requests for Non-Preferred PPIs:

Preferred Drug Trial 1: Drug Name & Dose_____ Trial Dates:_____

Failure Reason_____

Preferred Drug Trial 2: Drug Name & Dose_____ Trial Dates:_____

Failure Reason_____

Preferred Drug Trial 3: Drug Name & Dose_____ Trial Dates:_____

Failure Reason_____

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 (Must match prescriber listed above.)	Date of submission

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 Health and Human Services, that the member continues to be eligible for Medicaid.*