

PROTON PUMP INHIBITORS PRIOR AUTHORIZATION FORM

- Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.
- Prior authorization guidelines and quantity limits may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – Proton Pump Inhibitors and Quantity Limits/Daily Dose Limits, accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION REQUEST INFORMATION			PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request:	Prescriber name:	
<input type="checkbox"/> Renewal request	(PA# _____)	_____		
Name of office contact:			Specialty:	
Contact's phone number:			State license #:	
LTC facility contact/phone:			NPI:	MA Provider ID#:
RECIPIENT INFORMATION			Street address:	
Recipient Name:			Suite #:	City/State/Zip:
Recipient ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Preferred medication requested:	Non-preferred medication requested:
<input type="checkbox"/> Nexium suspension packet <input type="checkbox"/> omeprazole Rx capsule <input type="checkbox"/> pantoprazole tablet <input type="checkbox"/> Protonix suspension packet	<input type="checkbox"/> Aciphex tablet <input type="checkbox"/> Aciphex sprinkle <input type="checkbox"/> Dexilant capsule <input type="checkbox"/> esomeprazole magnesium DR capsule (generic Nexium Rx) <input type="checkbox"/> lansoprazole Rx capsule <input type="checkbox"/> lansoprazole OTC capsule <input type="checkbox"/> Nexium Rx capsule <input type="checkbox"/> Nexium 24HR OTC capsule <input type="checkbox"/> omeprazole OTC tablet <input type="checkbox"/> omeprazole magnesium OTC capsule <input type="checkbox"/> omeprazole/sodium bicarb Rx capsule <input type="checkbox"/> Prevacid Rx capsule <input type="checkbox"/> Prevacid 24HR OTC capsule <input type="checkbox"/> Prevacid SoluTab <input type="checkbox"/> Prilosec Rx capsule <input type="checkbox"/> Prilosec OTC tablet <input type="checkbox"/> Prilosec suspension packet <input type="checkbox"/> Protonix tablet <input type="checkbox"/> rabeprazole tablet <input type="checkbox"/> Zegerid Rx capsule <input type="checkbox"/> Zegerid packet <input type="checkbox"/> _____

Directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):	Dx code (<i>required</i>):	
Will the PPI be administered via feeding tube? <input type="checkbox"/> Yes: tube type (NG, NJ, etc): _____ tube size (width): _____ <input type="checkbox"/> No		

Complete each section applicable to the requested medication.

Section A: ALL non-preferred requests	
1. Does the Recipient have a history of trial and failure, contraindication, or intolerance to the preferred Proton Pump Inhibitors? <i>Check all that apply.</i> <input type="checkbox"/> Nexium suspension packet <input type="checkbox"/> pantoprazole tablet <input type="checkbox"/> omeprazole Rx capsule <input type="checkbox"/> Protonix suspension packet	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit all supporting documentation of medication name(s) and associated trial and failure, intolerance, and contraindications</i>

Section B: ALL requests (preferred and non-preferred) for Recipients under the age of 6 years	
2. What is the Recipient's weight? _____ pounds -or- _____ kilograms	
3. Has the Recipient been on a PPI for more than 4 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>
4. Is the PPI prescribed by, or in consultation with, a gastroenterologist?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation of consultation, if applicable.</i>
5. Does the Recipient have a chronic primary disease that requires chronic PPI therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>
6. Did the Recipient have a complete evaluation and diagnostic testing confirming a diagnosis that requires chronic PPI therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation of evaluation and test results.</i>

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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