



Request for Prior Authorization
PROTON PUMP INHIBITORS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, 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

- List of preferred PPI options: Esomeprazole Mag Caps, Pantoprazole Tabs, Lansoprazole Caps, Protonix Packet, Omeprazole Caps (RX), Rabeprazole Tabs, Nexium Packet.

Non-Preferred (PA required)

- List of non-preferred PPI options: Aciphex, Esomeprazole Packet, Omeprazole Sod Bicarb (RX), Protonix, Dexilant, Lansoprazole SoluTab, Pantoprazole Packet, Rabeprazole Caps, Dexlansoprazole, Naproxen/Esomeprazole, Prevacid, Vimovo, Nexium Caps, Prilosec (RX).

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

- Diagnosis options: Barrett's esophagus, Erosive esophagitis, or Peptic stricture; Hypersecretory conditions; Recurrent peptic ulcer disease; Gastroesophageal reflux disease; Active Helicobacter pylori 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
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**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.