AMIDACARE EXPRESS SCRIPTS®

Prior Authorization Form
Proton Pump Inhibitor

This form is based on Express Scripts standard criteria and may not be applicable to all patients; Amida Care may require additional information beyond what is specifically requested.

Fax completed form to **1-800-357-9577**

If this an **URGENT** request, please call 1-800-753-2851

Patient Information

Patient First Name: _____

Patient Last Name: _____

Patient ID#: _____

Patient DOB: _____

Patient Phone #: _____

Prescriber Information

Prescriber Name: _____

Prescriber DEA/NPI **(required)**: _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber Address: _____

State: _____ Zip Code: _____

Primary Diagnosis: _____ ICD Code: _____

Please indicate which drug and strength is being requested:

- ☐ Aciphex 20mg
- ☐ Dexilant 30mg
- ☐ Dexilant 60mg
- ☐ Lansoprazole 15mg ODT
- ☐ Lansoprazole 30mg ODT
- ☐ Nexium 20mg
- ☐ Nexium 40mg
- ☐ Nexium 10mg Powder for Suspension
- ☐ Nexium 20mg Powder for Suspension
- ☐ Nexium 40mg Powder for Suspension
- ☐ Omeprazole/sodium bicarbonate 20mg-1100mg
- ☐ Omeprazole/sodium bicarbonate 40mg-1100mg
- ☐ Prevacid 15mg Capsule
- ☐ Prevacid 30mg Capsule
- ☐ Prevacid Solutab 15mg
- ☐ Prevacid Solutab 30mg
- ☐ Prevacid 30mg Granules for Suspension
- ☐ Prilosec 10mg
- ☐ Prilosec 20mg
- ☐ Prilosec 40mg
- ☐ Prilosec 2.5mg Granules for Suspension
- ☐ Prilosec 10mg Granules for Suspension
- ☐ Prilosec OTC 20mg
- ☐ Protonix 20mg
- ☐ Protonix 40mg
- ☐ Protonix 40mg Granules for Suspension
- ☐ Zegerid 20mg Capsule
- ☐ Zegerid 40mg Capsule
- ☐ Zegerid 20mg Powder for Suspension
- ☐ Zegerid 40mg Powder for Suspension
- ☐ Zegerid OTC 20mg Capsule
- ☐ Zegerid OTC 40mg Capsule
- ☐ Zegerid OTC 20mg Powder/Suspension
- ☐ Zegerid OTC 40mg Powder/Suspension

Directions for use (i.e. QD, BID, PRN & Qty): _____

Please complete the clinical assessment:		
1. Is the patient currently taking the Proton Pump Inhibitor being requested? If yes, how long has the patient been taking the medication? _____	Yes	No

2. Has the patient tried one of the following medications under the supervision of a physician for at least 14 days? If yes, please indicate:	Yes	No
3. Is the medication being prescribed by a gastroenterologist or after consultation with a gastroenterologist?	Yes	No
4. Is the patient taking clopidogrel (Plavix)?	Yes	No
5. Is the patient pregnant?	Yes	No
6. Does the patient have a feeding tube?	Yes	No
7. If the diagnosis is Helicobacter pylori, has Helicobacter pylori infection been confirmed by one of the following tests: serologic testing, carbon isotope (C^{14}-Urea) breath test, or endoscopic examination followed by urease testing, histology, or culture?	Yes	No
8. Has the patient been on PPI therapy greater than 90 days and is still experiencing a recurrence of the same conditions or does not obtain control of symptoms? _____	Yes	No
9. Does the patient have risk factors for ulcers or was recently hospitalized for a GI medical condition? If yes please explain: ___ _____	Yes	No

Are there any other comments, diagnoses, symptoms, and/or any other information the physician feels is important to this review?

Prescriber Signature: _____ Date: _____

Office Contact Name: _____ Phone Number: __

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to Amida Care for the detailed information regarding benefits, conditions, limitations, and exclusions.