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; certain plans and situations may require additional information beyond what is specifically requested.
Additional forms available: www.express-scripts.com/pa

Fax completed form to **1-877-329-3760**
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 (generic for Zegerid 20mg-1100mg)
- ☐ Omeprazole/sodium bicarbonate 40mg-1100mg (generic for Zegerid 40mg-1100mg)
- ☐ Prevacid 24HR OTC Capsule
- ☐ Prevacid 15mg Capsule
- ☐ Prevacid 30mg Capsule
- ☐ Prevacid Solutab 15mg
- ☐ Prevacid Solutab 30mg
- ☐ 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. Is the patient taking samples or paying 100% out of pocket for the medication being requested? If no, please indicate: ☐ Requested medication covered under previous insurance plan ☐ Started medication in hospital ☐ Other: _____	☐ Yes	☐ No
3. Has the patient tried one of the following medications under the supervision of a physician for at least 14 days? If yes, please indicate: ☐ Aciphex ☐ Dexilant (formerly Kapidex) ☐ Lansoprazole capsules ☐ Lansoprazole orally disintegrating tablet ☐ Nexium ☐ Omeprazole OTC ☐ Omeprazole RX ☐ Omeprazole/sodium bicarbonate ☐ Pantoprazole ☐ Prevacid ☐ Prevacid 24HR ☐ Prevacid Solutab ☐ Prilosec RX ☐ Prilosec OTC ☐ Protonix ☐ Zegerid ☐ Zegerid OTC	☐ Yes	☐ No
4. Is the medication being prescribed by a gastroenterologist or after consultation with a gastroenterologist?	☐ Yes	☐ No
5. Is the patient taking clopidogrel (Plavix)?	☐ Yes	☐ No
6. Is the patient pregnant (if applicable)?	☐ Yes	☐ No
7. Does the patient have a feeding tube?	☐ Yes	☐ No
8. Is the participant post-bariatric surgery?	☐ Yes	☐ No

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

_____

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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 the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.