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 **1-800-357-9577**
If this an **URGENT** request, please call 1-800-417-8164

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 24HR OTC Capsule
- ☐ 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. 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

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.

The document(s) accompanying this transmission may contain confidential health information. This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you received this information in error, please notify the sender immediately and arrange for the return or destruction of the documents.