AmeriHealth

Prior Authorization Form

Proton Pump Inhibitors and Pylera

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: (check one) ☐ **Prevacid®** ☐ **Nexium®** ☐ **Nexium® suspension** ☐ **Aciphex®** ☐ **Protonix®**
☐ **Prevacid NapraPAC®(lansoprazole/naproxen)** ☐ **Pylera®** ☐ **Kapidex®**
☐ **Prevacid® solutabs or suspension** ☐ **Zegerid®** ☐ **Prilosec® suspension**

Date: _____ Patient ID#: _____ DOB:_____

Patient Name: _____ Provider NPI: _____

Prescribing Physician: _____ Office Contact: _____

Office Fax #: _____ Office Phone: _____

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. **DIAGNOSIS FOR DRUG REQUESTED (request will not be processed without diagnosis)**
   ☐ GERD ☐ Gastric Ulcer or PUD ☐ Other (specify)_____

2. **MEDICATION HISTORY** (Please list any previous or current therapy related to the diagnosis, using drug names and dates)
   ☐ **N/A** If none or not applicable to diagnosis, indicate "N/A."

Drug Name	Date	Duration

3. **PATIENT HISTORY**
   - **a.** Has the patient tried and failed prescription generic omeprazole or pantoprazole for at least 14 days? ☐ Yes ☐ No
   - **b.** Does the patient have a history of intolerance/allergy/contraindication to omeprazole, pantoprazole, Prevacid or Nexium? (specify):_____ ☐ Yes ☐ No
   - **c.** Has the patient tried any Esomeprazole (Nexium®) containing products? ☐ Yes ☐ No
   - **d.** Has the patient tried any Lansoprazole (Prevacid®) containing products? ☐ Yes ☐ No
   - **e.** Does the patient have a history of gastric ulcer? (NapraPAC® only) ☐ Yes ☐ No ☐ N/A
   - **f.** Does the patient have an inability to swallow capsules/tablets because of (dysphagia, GI tubes, etc.)? ☐ Yes ☐ No

Please add any other supporting medical information that may be useful in the decision-making process:

_____

_____

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only **Coverage effective date / /**

Document #_____ Processor Initials_____ Date_____

M F Rx coverage Y N STANDARD - SELECT LOB_____

Previous Auth Y N **Approved** **Reviewer Initials**_____ Date_____

AmeriHealth HMO, Inc. • AmeriHealth Insurance Company of New Jersey• QCC Insurance Company d/b/a AmeriHealth Insurance Company