AmeriHealth

Prior Authorization Form

PROTON PUMP INHIBITORS

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: (check one) ☐ **Prevacid®** ☐ **Nexium®** ☐ **Nexium® suspension** ☐ **Aciphex®** ☐ **Protonix®**
☐ **Protonix suspension** ☐ **Vimovo®** ☐ **Pylera®** ☐ **Kapidex®**
☐ **Prevacid® solutabs** ☐ **Zegerid®** ☐ **Prilosec® suspension** ☐ **Zegerid® packets**

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 , pantoprazole or lansoprazole for at least 14 days?(*specify in section above*) ☐ Yes ☐ No

b. Has the patient tried any Esomeprazole (Nexium®) containing products? ☐ Yes ☐ No

c. 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 including contraindications to the medications related to the diagnosis:

_____

_____

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