Prior Authorization Request Form for Proton Pump Inhibitors

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)

Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Proton Pump Inhibitors? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*

☐ Yes
☐ No

Medications Tried: [redacted]

☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

Therapeutic Duplication:
One of the following:

☐ is being titrated to or tapered from one Proton Pump Inhibitor to another with the intent of discontinuing one of the medications
☐ has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines; reasoning: [redacted]

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

CHILDREN UNDER 6 YEARS

☐ Has chronic primary disease such as cystic fibrosis, cerebral palsy, Down Syndrome, intellectual disability, or repaired esophageal atresia
☐ Has documentation of a comprehensive evaluation and appropriate diagnostic testing confirming a diagnosis that requires chronic therapy
☐ Is being prescribed the medication by or in consultation with a gastroenterologist

DUAL-ELIGIBLE MEMBERS

☐ For OTC PPI, both of the following:
  ☐ Is not being prescribed the OTC PPI as part of a Medicare Part D plan utilization management program, including step-therapy or prior authorization
  ☐ Has a history of therapeutic failure, contraindication, or intolerance to the PPIs on the member's Medicare Part D plan formulary

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)