

US Family Health Plan Pharmacy Program

Proton Pump Inhibitor Prior Authorization Request Form

This form applies to the US Family Health Plan Mail Order Pharmacy and the US Family Health Plan Retail Pharmacy programs. This form must be completed and signed by the prescriber.

PLEASE NOTE:

- **NO prior authorization is required for the preferred PPIs omeprazole and esomeprazole (Nexium). Both are available at a \$3 cost share.**
- **Prior authorization for the non-preferred PPIs Aciphex, Dexilant [formerly named Kapidex], Prevacid, Protonix, and Zegerid is NOT required for patients who are currently receiving PPIs based on prescriptions filled during the last 6 months.**

MAIL ORDER	If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here <input type="checkbox"/>	RETAIL	If the prescription is to be filled at a retail pharmacy, check here <input type="checkbox"/>
	<ul style="list-style-type: none"> • The completed form and the prescription may be faxed to 1-617-562-5296 OR • The patient may attach the completed form to the prescription and mail it to: Attn: Pharmacy, 77 Warren Street, Brighton, MA 02135 		<ul style="list-style-type: none"> • The provider may call: 1-877-880-7007 <li style="text-align: center; padding: 5px 0;">OR • The completed form may be faxed to 1-617-562-5296

Prior authorization criteria and a copy of this form are available at: http://www.usfamilyhealth.org/fdownloadable_forms.html

- Drug for which Prior Authorization is requested:**
- Aciphex (rabeprazole) Protonix (pantoprazole)
 - Dexilant [formerly Kapidex] Zegerid (omeprazole/sodiumbicarbonate) (dexlansoprazole)
 - Prevacid (lansoprazole)

Step 1 Please complete patient and physician information (Please Print)

1	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID: _____	Phone #: _____
	Date of Birth: _____	Secure Fax: _____

Step 2 Please complete the clinical assessment

1. Has the patient received a trial of omeprazole OR esomeprazole (Nexium) and had an inadequate response?	<input type="checkbox"/> Yes Please sign and date.	<input type="checkbox"/> No Proceed to Question 2
2. Has the patient received a trial of omeprazole OR esomeprazole (Nexium), but was unable to tolerate it due to adverse effects?	<input type="checkbox"/> Yes Please sign and date.	<input type="checkbox"/> No Proceed to Question 3
3. Is treatment with omeprazole or esomeprazole (Nexium) contraindicated for this patient (e.g., due to hypersensitivity)?	<input type="checkbox"/> Yes Please sign and date.	<input type="checkbox"/> No Proceed to Question 4
4. Is the patient currently receiving clopidogrel (Plavix) and requires the use of a non-preferred PPI?	<input type="checkbox"/> Yes Please sign and date.	<input type="checkbox"/> No Coverage not approved

Step 3 I certify the above is correct and accurate to the best of my knowledge. Please sign and date

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Prescriber Signature	Date
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