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EXPRESS SCRIPTS®
Charting the Future of Pharmacy

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Bloomington, MN 55439
PH # 1-800-789-6798

Proton Pump Inhibitor Appeal for Coverage Georgia Dept. of Community Health Only

FAX to: 877-697-7192

Note: If the Following Information is NOT filled in completely, correctly, or legibly the appeal process will be delayed. (One form per patient please)

Plan: Board of Regents State Health Benefit Plan GA Medicaid (circle one)

Patient's ID# _____

Patient's Full Name _____

Patient's Date of Birth _____

Medication Requested: _____ **Strength** _____

Directions _____ **Dosage Form** _____

Duration of Therapy Requested _____

Physician's Name _____

Physician's Address _____

Physician's Phone _____

Physician's Fax _____

Diagnosis-Indication-Medical History – including complications if relevant (reason for use of this medication) Please do not include documentation that is not requested on this form

Other prescription medications/therapies tried and reason(s) for failure:

Drug _____ **Strength** _____ **Directions** _____

Dates used: from _____ **to** _____ **Failed due to:** _____

Drug _____ **Strength** _____ **Directions** _____

Dates used: from _____ **to** _____ **Failed due to:** _____

Physician Signature _____

Contact Person _____

Express Scripts will provide a response within one business day