





## Multi-Ingredient Compound Drug Prior Authorization Request Form (Page 2 of 2)

**\*\*\*For compound requests containing Proton Pump Inhibitors (PPI) ONLY, please complete below (omeprazole and pantoprazole compound requests do not require PA). \*\*\***

**Select the diagnosis below:**

- Barrett's esophagus
- Duodenal ulcer/Gastric ulcer/Peptic Ulcer Disease (PUD)
- Erosive esophagitis
- Gastroesophageal reflux disease (GERD)
  - without complications
  - with complications- please specify: \_\_\_\_\_
- H. Pylori
- Prophylactic therapy following gastric bypass surgery
- Recent discharge from hospital (within the last 60 days) for an upper GI bleed, hemorrhage, perforation, or obstruction and already started in the hospital on PPI therapy
- Zollinger Ellison (ZE) Syndrome
- Other diagnosis: \_\_\_\_\_ ICD-10 Code(s): \_\_\_\_\_

**Select if the member has any of the following complicated disease states:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Anticoagulant therapy                 | <input type="checkbox"/> Cystic Fibrosis       | <input type="checkbox"/> Laryngopharyngeal reflux           |
| <input type="checkbox"/> Cancer                                | <input type="checkbox"/> Dysphagia             | <input type="checkbox"/> Multiple endocrine adenomas        |
| <input type="checkbox"/> Cerebral Palsy                        | <input type="checkbox"/> ESRD                  | <input type="checkbox"/> Neurological/neuromotor impairment |
| <input type="checkbox"/> Chronic oral corticosteroid/NSAID use | <input type="checkbox"/> Esophageal varices    | <input type="checkbox"/> Pancreatitis                       |
| <input type="checkbox"/> Chronic pulmonary disease             | <input type="checkbox"/> G-tube (gastric tube) | <input type="checkbox"/> Sleep apnea                        |
| <input type="checkbox"/> Congenital esophageal abnormality     | <input type="checkbox"/> Gastritis             | <input type="checkbox"/> Systemic mastocytosis              |
| <input type="checkbox"/> COPD                                  | <input type="checkbox"/> Hematemesis           | <input type="checkbox"/> Theophylline therapy               |
| <input type="checkbox"/> Crohn's                               | <input type="checkbox"/> Hiatal hernia         | <input type="checkbox"/> Post-transplant                    |

**Medication history:**

- Has the member completed a 30 days' supply for omeprazole in the past 6 months?  Yes  No
- Has the member completed a 30 days' supply for pantoprazole in the past 6 months?  Yes  No
- Is the requested medication being administered in a G-tube (gastric tube)?  Yes  No
- If **yes**, has the member tried and failed a 30-day trial of Prevacid Solutab?  Yes  No

**For Aciphex Sprinkle, prescription Nexium (capsules or granules) & prescription esomeprazole requests, also answer the following:**

- Is the member unable to swallow solid dosage forms (e.g., tablets, capsules)?  Yes  No
- Has the member tried and failed omeprazole?  Yes  No

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

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Please note: This request may be denied unless all required information is received.  
For urgent or expedited requests please call 1-866-525-5827.  
This form may be used for non-urgent requests and faxed to 1-888-491-9742.