GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Please note: All information below is required to process this request.
Mon-Fri: 8am to 1am Eastern / Sat: 9am to 6pm Eastern

Proton Pump Inhibitor Prior Authorization Request Form (Page 1 of 2)

Note: If the following information is NOT filled in completely, correctly, and/or legibly the PA process **can** be delayed.
Please complete one form for each member.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Barrett's esophagus
- ❑ Duodenal ulcer/Gastric ulcer/Peptic Ulcer Disease (PUD)/Reduction in risk of upper GI bleeding in critically ill
- ❑ Erosive esophagitis
- ❑ Gastroesophageal reflux disease (GERD)
  - ❑ without complications
  - ❑ with complications- please specify: _____
- ❑ H. Pylori
- ❑ Premature infants with GERD and feeding difficulties
- ❑ 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:

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

❑ Other complicated disease state (please specify): _____

Medication history:

Has the member completed a 30 days' supply of omeprazole in the past 6 months? ❑ **Yes** ❑ **No**
Has the member completed a 30 days' supply of pantoprazole in the past 6 months? ❑ **Yes** ❑ **No**
Has the member completed a 30 days' supply of prescription Nexium Granules 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 and prescription Nexium Granules? ❑ **Yes** ❑ **No**

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Is the member unable to swallow solid dosage forms (e.g., tablets, capsules)? ❑ **Yes** ❑ **No**

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Proton Pump Inhibitor Prior Authorization Request Form (Page 2 of 2)

Physician Signature: _____

Contact Person: _____

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

_____

_____

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.

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