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)
- ❑ 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**

**For Aciphex Sprinkle and 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 or prescription Nexium Granules? ❑ **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.