

Proton Pump Inhibitor Prior Authorization Request Form



5591

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Pharmacy Program (TPharm). Express Scripts is the contractor for DoD.

PLEASE NOTE:

- **NO prior authorization is required for omeprazole or esomeprazole (Nexium). Both are available at a \$3 cost share.**
- **Prior authorization for 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 and RETAIL	<ul style="list-style-type: none"> • The provider may call: 1-866-684-4488 or the completed form may be faxed to: 1-866-684-4477 • The patient may attach the completed form to the prescription and mail it to: Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954 or email the form only to: TpharmPA@express-scripts.com
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Prior authorization criteria and a copy of this form are available at: http://pec.ha.osd.mil/forms_criteria.php.

Drug for which Prior Authorization is requested:

- | | |
|--|--|
| <input type="checkbox"/> Aciphex (rabeprazole) | <input type="checkbox"/> Protonix (pantoprazole) |
| <input type="checkbox"/> Dexilant [formerly <i>Kapidex</i>] (dexlansoprazole) | <input type="checkbox"/> Zegerid (omeprazole/sodium bicarbonate) |
| <input type="checkbox"/> Prevacid (lansoprazole) | |

Step 1 Please complete patient and physician information (please print)

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 Coverage not approved

Step 3 I certify that the above is correct to the best of my knowledge (please sign and date):

 Prescriber Signature Date