PRO ACT
PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

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

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
❑ Erosive esophagitis
❑ Gastric ulcer
❑ Gastrointestinal bleed
❑ Gastroesophageal reflux disease (GERD)
❑ Helicobacter pylori gastrointestinal tract infection
❑ Laryngopharyngeal reflux/spasm
❑ Non-steroidal anti-inflammatory drug (NSAID) gastropathy
❑ Pathological hypersecretory conditions including Zollinger-Ellison Syndrome
❑ Ulcerative esophagitis
❑ Other diagnosis:______________________________ ICD-10 Code(s): ____________________________________

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Dexilant
❑ Esomeprazole
❑ Lansoprazole capsule
❑ Omeprazole
❑ Pantoprazole

Quantity limit requests:

What is the quantity requested per day? _________

Has the patient had a failure to once-daily proton pump inhibitor regimen? ❑ **Yes** ❑ **No**

If the patient's diagnosis is Barrett's esophagus, is there a need for complete acid control? ❑ **Yes** ❑ **No**

If the patient's diagnosis is GERD, is the patient's GERD symptomatic? ❑ **Yes** ❑ **No**

Does the patient have presence of extraesophageal symptoms (exacerbation of cough or asthma, non-cardiac chest pain, dysphagia)? ❑ **Yes** ❑ **No**

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: ____

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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.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): ______________________ **Date:** __________

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	

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