

SENTARA COMMUNITY PLAN (MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Proton Pump Inhibitors (PPI) Drugs

Drug Requested: (check box below that applies)

PREFERRED PPIs			
<input type="checkbox"/> omeprazole RX		<input type="checkbox"/> pantoprazole tablets	
<input type="checkbox"/> Protonix [®] suspension		<input type="checkbox"/> pantoprazole suspension	
Non-Preferred PPIs			
<input type="checkbox"/> Aciphex [®] DR tab/sprinkle	<input type="checkbox"/> Dexilant [®] and generic dexlansoprazole DR	<input type="checkbox"/> esomeprazole magnesium	<input type="checkbox"/> esomeprazole strontium
<input type="checkbox"/> lansoprazole cap	<input type="checkbox"/> Nexium [®]	<input type="checkbox"/> Omeprazole OTC	<input type="checkbox"/> omeprazole magnesium OTC
<input type="checkbox"/> omeprazole/sodium bicarbonate	<input type="checkbox"/> Prevacid [®] RX, OTC, & Solutab	<input type="checkbox"/> rabeprazole DR tab	<input type="checkbox"/> Prilosec [®] RX & Susp
<input type="checkbox"/> Protonix [®] tablets	<input type="checkbox"/> Zegerid [®] cap, OTC, susp packet		

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

(Continued on next page)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

1. Request type: Initial Request Renewal Request

NOTE: PDL Criteria must be met first before a non-preferred PPI may be approved.

Initial requests - may be authorized for 12 weeks only.

Renewal requests – for both Preferred and non-preferred PPI usage for greater than 3 months may be allowed for 1 year **ONLY** if one of the following exceptions has been met:

Member is under the care of a Gastroenterologist **OR** member has a diagnosis of **ACTIVE** GI Bleed, Erosive Esophagitis, Gastroesophageal Reflux Disease, Pathological Hypersecretory Syndrome, Unhealed Gastric, Duodenal or Peptic Ulcer, Barrett’s Esophagus or Zollinger-Ellison Syndrome.

2. Has member had a therapeutic failure of no less than a **3-month trial** of at least **TWO Preferred PPIs**?

Yes No

a. If **YES**, list medications.

Drug 1: _____ **Strength:** _____ **Date:** _____

Drug 2: _____ **Strength:** _____ **Date:** _____

Drug 3: _____ **Strength:** _____ **Date:** _____

b. If **NO**, document compelling details.

3. Has member seen a Gastroenterologist?

Yes No

If **YES**, document name: _____

4. Does member have one of the following conditions?

- | | | |
|---|------------------------------|-----------------------------|
| a. GI Bleeds | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Zollinger-Ellison Syndrome | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Gastroesophageal Reflux Disease GI Bleeds | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Pathological Hypersecretory Syndrome | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Unhealed Gastric, Duodenal or Peptic Ulcer GI Bleeds | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Barrett’s Esophagus | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Erosive Esophagitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Medical Necessity (provide clinical evidence that the Preferred drug(s) will not provide adequate benefit):

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.