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			
❑ **omeprazole RX**		❑ **pantoprazole tablets**	
❑ **Protonix® suspension**		❑ **pantoprazole suspension**	
Non-Preferred PPIs			
❑ **Aciphex® DR** tab/sprinkle	❑ **dexlansoprazole dr** (generic Dexilant®)	❑ **Dexilant®**	❑ **esomeprazole magnesium cap/sus/tab**
❑ **esomeprazole strontium**	❑ **lansoprazole cap**	❑ **Konvomep®**	❑ **Nexium®**
❑ **omeprazole OTC**	❑ **Omeprazole magnesium OTC**	❑ **omeprazole/sodium bicarbonate**	❑ **Prevacid® RX, OTC, & Solutab**
❑ **Prilosec® RX & Susp**	❑ **Protonix® tablets**	❑ **rabeprazole DR tab**	

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:** _____

NPI #: _____

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DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

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.

_____

_____

_____

_____

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3. Has member seen a Gastroenterologist?

   ❑ Yes ❑ No

   If **YES**, document name: _____

4. Does member have one of the following conditions?
   a. GI Bleeds ❑ Yes ❑ No
   b. Zollinger-Ellison Syndrome ❑ Yes ❑ No
   c. Gastroesophageal Reflux Disease GI Bleeds ❑ Yes ❑ No
   d. Pathological Hypersecretory Syndrome ❑ Yes ❑ No
   e. Unhealed Gastric, Duodenal or Peptic Ulcer GI Bleeds ❑ Yes ❑ No
   f. Barrett's Esophagus ❑ Yes ❑ No
   g. Erosive Esophagitis ❑ Yes ❑ 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.****

REVISED/UPDATED/REFORMATTED: ~~6/30/2017~~; ~~8/4/2017~~; ~~8/31/2017~~; ~~8/29/2018~~; ~~10/24/2018~~; ~~3/13/2019~~; ~~3/31/2019~~; ~~12/7/2019~~, ~~12/09/2021~~; ~~7/8/2022~~; ~~11/9/2023~~, **10/20/2025**