

Proton Pump Inhibitors - Washington Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.

**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.**

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

Section B - Provider Information

First Name:	Last Name:	M.D./D.O.	
Address:	City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax attention to:			

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

ALL REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this request for tapering and discontinuation purposes?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the requested medication being used for any the following? (If yes, check which applies) <input type="checkbox"/> Barrett's esophagus <input type="checkbox"/> Esophageal stenosis/stricture or Schatzki ring <input type="checkbox"/> Long-term use with bisphosphonates <input type="checkbox"/> Long-term use with certain concurrent therapies <input type="checkbox"/> Pathological gastric acid hypersecretion, such as Zollinger-Ellison syndrome <input type="checkbox"/> Recent duodenal ulcer <input type="checkbox"/> Recent erosive/ulcerative esophagitis <input type="checkbox"/> Recent gastric ulcer

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of failure, contraindication, or intolerance to any preferred alternatives? (If yes, complete Section D above)
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BARRETT'S ESOPHAGUS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Will documentation be submitted along with this fax that includes the most current EGD (esophagogastroduodenoscopy) report from within the last 5 years with clinical diagnosis?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will documentation be submitted along with this fax that includes a corresponding pathology report showing histological confirmation of intestinal metaplasia in esophageal biopsies?

ESOPHAGEAL STENOSIS/STRICTURE OR SCHATZKI RING

<input type="checkbox"/> Yes <input type="checkbox"/> No	Will documentation be submitted along with this fax that includes an EGD report with clinical diagnosis?
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LONG TERM USE WITH BISPHOSPHONATES

<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient filled a bisphosphonate within the last 30 days?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient tried/failed residronate?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient's symptoms persist despite swallowing the bisphosphonate with a full glass of water and remaining upright after swallowing the bisphosphonate?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have pre-existing esophageal disorders?

LONG TERM USE WITH CERTAIN CONCURRENT THERAPIES (Continued on next page)

<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient filled a chronic NSAID (non-steroidal anti-inflammatory drug), including aspirin greater than or equal to 325mg per day, within the last 30 days?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient filled a chronic low-dose aspirin within the last 30 days and an EGD report from within the last 10 years shows a history of a GI (gastrointestinal) bleed?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient filled a chronic high-dose systemic steroid within the last 30 days?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient filled an antiplatelet or anticoagulant within the last 30 days?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient filled a pancreatic enzyme within the last 30 days?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient on concurrent cancer therapy and the PPI (proton pump inhibitor) is prescribed by or in consultation with an oncologist?

PATHOLOGICAL GASTRIC ACID HYPERSECRETION, SUCH AS ZOLLINGER-ELLISON SYNDROME

<input type="checkbox"/> Yes <input type="checkbox"/> No	Will documentation be submitted along with this fax that includes a consultation note from the gastroenterologist documenting diagnosis of pathological gastric acid hypersecretion?
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RECENT DUODENAL ULCER

<input type="checkbox"/> Yes <input type="checkbox"/> No	Will documentation be submitted along with this fax that includes an EGD report with clinical diagnosis of less than 1 year?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will documentation be submitted along with this fax that includes all Helicobacter pylori biopsy or breath/stool tests (negative test, or positive test then subsequent negative test after triple/quadruple therapy)?

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Member First name:	Member Last name:	Member DOB:
RECENT EROSION/ULCERATIVE ESOPHAGITIS		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will documentation be submitted along with this fax that includes all EGD reports within the last 16 months with LA (Los Angeles) classification?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will documentation be submitted along with this fax that includes all Helicobacter pylori biopsy or breath/stool tests (negative test, or positive test then subsequent negative test after triple/quadruple therapy)?	
RECENT GASTRIC ULCER		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will documentation be submitted along with this fax that includes EGD report with clinical diagnosis of less than 60 days?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will documentation be submitted along with this fax that includes all Helicobacter pylori biopsy or breath/stool tests (negative test, or positive test then subsequent negative test after triple/quadruple therapy)?	

Provider Signature: _____ **Date:** _____

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