UnitedHealthcare Community Plan

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: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ 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? □ Yes □ 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

UnitedHealthcare Community Plan

Proton Pump Inhibitors - Washington
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS	
□ Yes □ No	**Is this request for tapering and discontinuation purposes?**
□ Yes □ No	**Is the requested medication being used for any the following?** (*If yes, check which applies)* □ Barrett's esophagus □ Esophageal stenosis/stricture or Schatzki ring □ Long-term use with bisphosphonates □ Long-term use with certain concurrent therapies □ Pathological gastric acid hypersecretion, such as Zollinger-Ellison syndrome □ Recent duodenal ulcer □ Recent erosive/ulcerative esophagitis □ Recent gastric ulcer
□ Yes □ No	**Does the patient have a history of failure, contraindication, or intolerance to any preferred alternatives?** *(If yes, complete Section D above)*
BARRETT'S ESOPHAGUS	
□ Yes □ 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?**
□ Yes □ 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	
□ Yes □ No	**Will documentation be submitted along with this fax that includes an EGD report with clinical diagnosis?**
LONG TERM USE WITH BISPHOSPHONATES	
□ Yes □ No	**Has the patient filled a bisphosphonate within the last 30 days?**
□ Yes □ No	**Has the patient tried/failed residronate?**
□ Yes □ No	**Does the patient's symptoms persist despite swallowing the bisphosphonate with a full glass of water and remaining upright after swallowing the bisphosphonate?**
□ Yes □ No	**Does the patient have pre-existing esophageal disorders?**
LONG TERM USE WITH CERTAIN CONCURRENT THERAPIES ***(Continued on next page)***	
□ Yes □ 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?**
□ Yes □ 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?**
□ Yes □ No	**Has the patient filled a chronic high-dose systemic steroid within the last 30 days?**
□ Yes □ No	**Has the patient filled an antiplatelet or anticoagulant within the last 30 days?**
□ Yes □ No	**Has the patient filled a pancreatic enzyme within the last 30 days?**
□ Yes □ 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	
□ Yes □ No	**Will documentation be submitted along with this fax that includes a consultation note from the gastroenterologist documenting diagnosis of pathological gastric acid hypersecretion?**
RECENT DUODENAL ULCER	
□ Yes □ No	**Will documentation be submitted along with this fax that includes an EGD report with clinical diagnosis of less than 1 year?**
□ Yes □ 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)?**

UnitedHealthcare Community Plan

Proton Pump Inhibitors - Washington
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

RECENT EROSIVE/ULCERATIVE ESOPHAGITIS	
□ Yes □ No	**Will documentation be submitted along with this fax that includes all EGD reports within the last 16 months with LA (Los Angeles) classification?**
□ Yes □ 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	
□ Yes □ No	**Will documentation be submitted along with this fax that includes EGD report with clinical diagnosis of less than 60 days?**
□ Yes □ 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:** _____