Prior Authorization Request Form for
Proton Pump Inhibitors (PPIs): Esomeprazole capsules (**Nexium**, generics), Rabeprazole (**Aciphex**, generics)

JOHNS HOPKINS MEDICINE
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth _____ Secure Fax #: _____

Step 2 **Please complete the clinical assessment:**

1. Does the prescriber acknowledge that omeprazole capsules and pantoprazole tablets are the Department of Defense's preferred Proton Pump Inhibitors?	☐ **Yes** Proceed to question **2**	☐ **No** **STOP** **Coverage not approved**
2. Does the prescriber acknowledge that omeprazole capsules and pantoprazole tablets are available without a prior authorization?	☐ **Yes** Proceed to question **3**	☐ **No** **STOP** **Coverage not approved**
3. Has the patient received a trial of omeprazole capsules (Prilosec) and had an inadequate response or adverse reaction?	☐ **Yes** **Sign and date below**	☐ **No** Proceed to question **4**
4. Has the patient received a trial of pantoprazole tablets (Protonix) and had an inadequate response or adverse reaction?	☐ **Yes** **Sign and date below**	☐ **No** Proceed to question **5**
5. Does the patient have a contraindication to omeprazole (Prilosec) AND pantoprazole (Protonix)?	☐ **Yes** **Sign and date below**	☐ **No** **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered:

[27 November 2019]