Prior Authorization Request Form for
Proton Pump Inhibitors: lansoprazole ODT (**Prevacid Solutab**),
omeprazole/sodium bicarbonate packets for suspension **(Zegerid)**

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.

Prior authorization is not required for patients younger than 18 years of age.

NO prior authorization is required for uniform formulary proton pump inhibitors [PPIs] omeprazole capsules and packets for suspension (Prilosec), pantoprazole tablets and packets for suspension (Protonix), esomeprazole packets for suspension (Nexium, generics), and rabeprazole sprinkles (Aciphex). Lansoprazole ODT (Prevacid solutab), and omeprazole/sodium bicarbonate packets for suspension (Zegerid) are non-formulary and non-preferred PPIs and also require a prior authorization.

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 provider acknowledge that omeprazole and pantoprazole tablets and capsules are Uniform Formulary and do not require prior authorization?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the provider acknowledge that omeprazole, esomeprazole, and pantoprazole packets for suspension and rabeprazole sprinkles are Uniform Formulary and do not require prior authorization?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**

3. Please provide patient-specific clinical rationale of why the patient cannot take ALL alternative PPI agents below.

omeprazole capsules: _____
omeprazole packets: _____
pantoprazole tablets: _____
pantoprazole packets: _____
esomeprazole capsules: _____
esomeprazole packets: _____
rabeprazole tablets: _____
rabeprazole sprinkles: _____

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

_____ _____
Prescriber Signature Date

[27 November 2019]

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