Priority Partners MCO
7231 Parkway Drive, Suite 100
Hanover, MD 21076

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Prior Authorization

JOHNS HOPKINS HEALTHCARE (MEDICAID)

High Dose Proton Pump Inhibitors - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Healthcare at **1-410-424-4607**.
Please contact Johns Hopkins Healthcare at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of High Dose Proton Pump Inhibitors - Priority Partners MCO.

Drug Name
(specify drug) _____

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

**Diagnosis:** _____ **ICD Code:** _____

Comments: _____

**Please circle the appropriate answer for each question.**

1. Is this request for use in combination with appropriate antibacterial agents in a H. pylori eradication regimen? Y N

[Note: Documentation must be submitted.]

[If yes, then no further questions.]

2. Is this request for continuation of therapy? Y N

| | | | |
|---|---|---|---|
| | [Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.] | | |
| | [If no, then skip to question 5.] | | |
| 3. | Is the patient showing continued beneficial response to treatment? | Y N | |
| | [Note: Clinical documentation must be submitted.] | | |
| | [If no, then no further questions.] | | |
| 4. | Is this request for a patient with Zollinger Ellison syndrome or Barrett's esophagus? | Y N | |
| | [No further questions.] | | |
| 5. | Is this request for use as first-line therapy for the treatment of gastroesophageal reflux disease (GERD), peptic ulcer disease (PUD), or erosive esophagitis? | Y N | |
| | [If yes, then no further questions.] | | |
| 6. | Is the requested drug being prescribed for any of the following: A) Diagnosis of gastric hypersecretion, B) Diagnosis of laryngopharyngeal reflux, C) Gastroesophageal reflux disease (GERD) in a patient who has severe esophageal dysmotility? | Y N | |
| | [Note: Documentation must be submitted.] | | |
| | [If yes, then no further questions.] | | |
| 7. | Does the patient have gastroesophageal reflux disease (GERD), peptic ulcer disease (PUD), or erosive esophagitis, and continues to experience GI symptoms despite therapy with two different once-daily proton pump inhibitors (PPIs)? | Y N | |
| | [Note: An adequate therapy trial would consist of 8 weeks of usage for each proton pump inhibitor.] \ [Note: Documentation must be submitted.] | | |
| | [If yes, then no further questions.] | | |
| 8. | Does the patient have the diagnosis of Zollinger-Ellison syndrome or Barrett's esophagus? | Y N | |
| | [Note: Documentation must be submitted.] | | |

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

| |
|---|
| **Prescriber (Or Authorized) Signature and Date** |