



**Independence  
Blue Cross**

**Prior Authorization Form  
Proton Pump Inhibitors and Pylera**

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

Drug Requested: (check one)  Prevacid®  Nexium®  Nexium® suspension  Aciphex®  Protonix®  
 Prevacid NapraPAC® (lansoprazole/naproxen)  Pylera®  Kapidex®  
 Prevacid® solutabs or suspension  Zegerid®  Prilosec® suspension

Date: \_\_\_\_\_ Patient ID#: \_\_\_\_\_ DOB: \_\_\_\_\_  
Patient Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_  
Prescribing Physician: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
Office Fax #: \_\_\_\_\_ Office Phone: \_\_\_\_\_

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

**1. DIAGNOSIS FOR DRUG REQUESTED (request will not be processed without diagnosis)**

GERD  Gastric Ulcer or PUD  Other (specify) \_\_\_\_\_

**2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)**

N/A If none or not applicable to diagnosis, indicate "N/A."

Drug Name	Date	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

**3. PATIENT HISTORY**

- a. Has the patient tried and failed prescription generic omeprazole or pantoprazole for at least 14 days?  Yes  No
- b. Does the patient have a history of intolerance/allergy/contraindication to omeprazole, pantoprazole, Prevacid or Nexium? (specify): \_\_\_\_\_  Yes  No
- c. Has the patient tried any Esomeprazole (Nexium®) containing products?  Yes  No
- d. Has the patient tried any Lansoprazole (Prevacid®) containing products?  Yes  No
- e. Does the patient have a history of gastric ulcer? (NapraPAC® only)  Yes  No  N/A
- f. Does the patient have an inability to swallow capsules/tablets because of (dysphagia, GI tubes, etc.)?  Yes  No

Please add any other supporting medical information that may be useful in the decision-making process:

\_\_\_\_\_  
\_\_\_\_\_

**FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.**

<b>Internal use only</b>	<b>Coverage effective date</b> / /
Document # _____	Processor Initials _____ Date _____
M F Rx coverage Y N	STANDARD - SELECT LOB _____
Previous Auth Y N	<b>Approved</b> Reviewer Initials _____ Date _____