

Ticket #: _____ Request Date: _____ Request Time: _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of PPIs. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information			
Patient Name:		Plan Name/Plan ID:	
Patient ID:		Patient Date of Birth:	Patient Contact Phone #:
B. Physician Information			
Physician Name:		Physician Address:	
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	QTY and Days Supply:	NDC # and GCN:	
C. Pharmacy Information			
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:
D. Clinical Information (Please fill out the following information.)			
1. Does the patient have one of the following diagnoses? (check all that apply)		YES	NO
<input type="checkbox"/> Barret's esophagitis <input type="checkbox"/> Pathological Hypersecretory Condition <input type="checkbox"/> Zollinger-Ellison Syndrome			
2. Has the patient had at least a 30-day history on any of the following PPI drugs?		YES	NO
If YES, please check all that apply and indicated dates of therapy:			
<input type="checkbox"/> Aciphex: dates of therapy: _____		<input type="checkbox"/> Prilosec: dates of therapy: _____	
<input type="checkbox"/> Dexilant: dates of therapy: _____		<input type="checkbox"/> Protonix: dates of therapy: _____	
<input type="checkbox"/> Nexium: dates of therapy: _____		<input type="checkbox"/> Zegerid: dates of therapy: _____	
<input type="checkbox"/> Prevacid: dates of therapy: _____			
3. Does the patient have one of the following diagnoses? (check all that apply)		YES	NO
<input type="checkbox"/> Duodenal Ulcer Maintenance <input type="checkbox"/> Recurrent Gastroesophageal Reflux Disease (GERD) <input type="checkbox"/> Benign Gastric Ulcer <input type="checkbox"/> History of Gastric Ulcers <input type="checkbox"/> Erosive Esophagitis			
4. Does the patient have a diagnosis of H. pylori and is receiving concurrent antibiotic therapy [e.g. amoxicillin, clarithromycin, metronidazole, tetracycline, Levaquin [®] (at least 2 of 3)] with the PPI prescription?		YES	NO
5. Has the patient currently been on this medication? If YES, please indicate length of time: _____		YES	NO
Authorized Medical Signature:			
Telephone:		Date:	

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
 1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.