

Pharmacy Prior Authorization Form

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Aciphex (rabeprazole)

 Urgent

 Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

 Aciphex 20 mg

Dose: _____ Start date: _____

Priority Health Precertification Requirement:

Authorization of Aciphex requires:

- Documented therapeutic trial of the Prilosec OTC or omeprazole (minimum of 14 days of use within the past 13 months)
- Documented therapeutic trial of pantoprazole (minimum of 14 days of use within the past 13 months)
- Authorization of Aciphex is limited to once daily use

Please Complete the Following Information:

Documented therapeutic trial with **both** of the following medications:

<input type="checkbox"/> Yes	Dose	Dates	Outcome
<input type="checkbox"/> Prilosec OTC or omeprazole	_____	_____	_____
<input type="checkbox"/> Pantoprazole	_____	_____	_____
<input type="checkbox"/> No – Rationale for use: _____			

Request is for once daily dosing:

Yes

No – Rationale for use: _____

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX