

# 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

## Nexium (esomeprazole)/Dexilant (dexlansoprazole)

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:

- |                                       |                                         |
|---------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Nexium 20 mg | <input type="checkbox"/> Dexilant 30 mg |
| <input type="checkbox"/> Nexium 40 mg | <input type="checkbox"/> Dexilant 60 mg |

Dose: \_\_\_\_\_ Start date: \_\_\_\_\_

### Priority Health Precertification Requirement:

#### Authorization 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)
- Documented therapeutic trial of Prevacid OTC or lansoprazole (minimum of 14 days of use within the past 13 months) – **Not Required for Medicare**
- Documented therapeutic trial of Aciphex (minimum of 14 days of use within the past 13 months)
- Authorization is limited to once daily use

### Please Complete the Following Information:

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

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

Request is for once daily dosing:

- Yes
- No – Rationale for use: \_\_\_\_\_

**For Medicare only:** If none of the above is applicable to this member, please check which, if any, of the following apply:

- All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
  
- The number of doses available under a dose restriction for the prescription drug:
  - Has been ineffective in the treatment of the enrollee's disease or medical condition or,
  - Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance
  
- The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
  - Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
  - Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
  
- None of the above apply

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

**Please fax this request to: (877)974-4411 toll free or (616)942-8206  
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**