PA Request Criteria

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CAREFIRST ASO
Zegerid

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Zegerid.

Patient Name: _____ **Date:** 11/27/2023
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **NPI#:** **Patient Phone:** _____ **Physician Name:**
Specialty:
Physician Office Telephone:
Physician Office Address: _____
_
Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1. Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to THREE generic proton pump inhibitors? [If yes, then documentation is required for approval.] Document the drug names: _____ **Y** ☐ **N** ☐
2. Is this request for Zegerid? **Y** ☐ **N** ☐
3. Is the requested drug being prescribed for any of the following: A) Gastroesophageal reflux disease (GERD), B) Duodenal ulcer, C) Gastric ulcer, D) Short-term treatment of erosive esophagitis? **Y** ☐ **N** ☐
4. Does the patient require more than the plan allowance of 30 capsules or 30 packets for oral suspension per month? **Y** ☐ **N** ☐
5. Is the requested drug being prescribed for the maintenance of healing of erosive esophagitis? **Y** ☐ **N** ☐
6. Does the patient require more than the plan allowance of 30 capsules or 30 packets for oral suspension per month? **Y** ☐ **N** ☐
7. Is the requested drug being prescribed for the short-term treatment of gastric ulcer? **Y** ☐ **N** ☐
8. Does the patient require more than the plan allowance of 600 mL of Konvomep per month? **Y** ☐ **N** ☐

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