BlueCross BlueShield Federal Employee Program®

PROTON PUMP INHIBITORS (PPI) PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

NOTE: Form must be completed in its **entirety** for processing

Please indicate which medication is being requested:

❑**Aciphex tab (rabeprazole)**	❑**First-Lansoprazole susp**	❑**Protonix (pantoprazole)**
❑**Aciphex sprinkle cap (rabeprazole)**	❑**First-Pantoprazole susp**	❑**Nexium cap (esomeprazole magnesium)**
❑**Dexilant (dexlansoprazole)**	❑**Prevacid (lansoprazole)**	❑**Nexium packets for susp (esomeprazole magnesium)**
❑**Esomeprazole Strontium**	❑**Prevacid Solutab (lansoprazole)**	❑**Zegerid (omeprazole/sodium bicarbonate)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

*****Non-covered branded medications must go through prior authorization and the formulary exception process**

Is the request for brand or generic? ❑Brand ❑Generic

1. Will the patient need more than 270 dosage units every 90 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ capsules per 90 days
2. Dosing Directions: _____
3. **Requests for Nexium Packets *(please select strength)*: ❑2.5mg ❑5mg ❑10mg ❑20mg ❑40mg**
4. What is the patient's diagnosis?
   - ❑Barrett's esophagitis
   - ❑Erosive esophagitis
   - ❑Esophagitis
   - ❑GI bleed
   - ❑Sclerodermal esophagitis (part of CREST syndrome)
   - ❑Ulcer (duodenal, gastric, peptic ulcer disease (PUD))
   - ❑Zollinger-Ellison syndrome
   - ❑Gastropathy
     a. What is causing the patient's gastropathy? ❑Mobic or NSAID related ❑Other cause (non-medication related) ❑Other medication ***(please specify)***: _____
   - ❑GERD (gastroesophageal reflux disease including esophageal, laryngeal, and pharyngeal reflux)
   - ❑H. Pylori
     a. Is the patient currently undergoing treatment for H. Pylori in combination with antibiotic therapy? ❑Yes ❑No
   - ❑Hypersecretory disease (pancreatitis, multiple endocrine adenomas, systemic macrocytosis, cystic fibrosis)
   - ❑Other ***(please specify)***: _____ ***(answer the following question)***
     a. Is the patient being treated for a GI related diagnosis? ❑Yes ❑No
5. Will the requested medication be compounded into a suspension by the pharmacy? ❑Yes ❑No
6. What is the prescriber's specialty? ***Please select specialty below:***
   ❑Ear, Nose and Throat Specialist (ENT) (or other throat specialist) ❑Gastroenterologist (GI) ❑Pulmonologist
   ❑Other ***(please specify)***: _____
7. Has the patient tried and failed either an H2 blocker or another PPI other than the one currently being requested? ❑Yes* ❑No
   If YES, please select the H2 blocker or PPI previously tried and failed below:

H2 Blockers:	**PPIs:**	
❑Axid/Axid AR (nizatidine)	❑Aciphex (rabeprazole)	❑Prilosec/Prilosec OTC (omeprazole)
❑Pepcid/Pepcid AC (famotidine)	❑Dexilant (dexlansoprazole)	❑Protonix (pantoprazole)
❑Tagamet/Tagamet HB (cimetidine)	❑Nexium (esomeprazole)	❑Vimovo (esomeprazole)
❑Zantac/Zantac 75 (ranitidine)	❑Prevacid/Prevacid 24HR OTC (lansoprazole)	❑Zegerid/Zegerid (OTC) (omeprazole)

❑Other ***(please specify)***:_____

