Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Proton Pump Inhibitors (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Proton Pump Inhibitors (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name

Specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Patient information

Patient name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this member (i.e., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 8.]

2. Has the member previously been treated with high dose PPI (proton pump inhibitors)? Y N

   [If no, then skip to question 4.]

3. Has the member failed step-down to once daily dosing after completion of high dose course? Y N

   Please provide rationale for continued high dose:

[No further questions.]

4. Is this a request for a quantity limit exception (high dose)? (Refer to formulary for quantity limits) Y N

   [If no, then skip to question 7.]

5. Does the member have the diagnosis of Severe erosive esophagitis, Esophageal stricture, or Zollinger-Ellison syndrome? Y N

   [If yes, then no further questions.]

6. Did the member have unsatisfactory or partial response to once daily dosing or continues with night-time symptoms? Y N

   [No further questions.]

7. Is the member responding to therapy? Y N

   [No further questions.]

8. Is this request for one of the following agents: brand Prevacid SoluTab, Prilosec granules, Aciphex sprinkles, Protonix granules or Nexium granules (suspension)? Y N

   [If no, then skip to question 11.]

9. Is the member unable to swallow tablets/capsules or is using a feeding tube for medications? Y N

   [If no, then no further questions.]

10. Has the member had a trial and failure with BOTH First-omeprazole and First-lansoprazole? Y N

    [If yes, then skip to question 14.]

    [If, no, then no further questions.]

11. Is this request for one of the following agents: Dexilant, esomeprazole Rx (prescription) or omeprazole/sodium bicarbonate? Y N

    [If no, then skip to question 14.]

12. Has the member had a trial and failure of at least TWO formulary PPIs (proton pump inhibitors)? (Refer to formulary for preferred agents) Y N

    Please document medications tried:

_____

[If no, then no further questions.]

13. Has the member had a trial and failure of one additional formulary PPI (proton pump inhibitors) at double the usual starting dose (i.e., omeprazole 40mg, Nexium OTC (over the counter) 40mg, lansoprazole 30mg, pantoprazole 40mg, rabeprazole 40mg.) Y N

    Please document medication tried:

    _____

    [If no, then no further questions.]

14. Is this a request for a quantity limit exception (high dose)? (Refer to formulary for quantity limits) Y N

    [If no, then no further questions.]

15. Does the member have the diagnosis of Severe erosive esophagitis, Esophageal stricture, or Zollinger-Ellison syndrome? Y N

    [If yes, then no further questions.]

16. Did the member have unsatisfactory or partial response to once daily dosing or continues with night-time symptoms? Y N

Comments:

_____

_____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature **Date**