AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Proton Pump Inhibitors

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is not required for the preferred proton pump inhibitors (PPI) for doses within the established quantity limits of one unit per day. Payment for a non-preferred PPI will be authorized only for cases in which there is documentation of previous trials and therapy failures with three preferred agents.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Preferred:	**Non-Preferred (PA required)**		
☐ Dexilant	☐ Aciphex	☐ Omeprazole/Sodium Bicarb (RX)	☐ Protonix
☐ Omeprazole Caps (RX)	☐ Esomeprazole	☐ Prevacid	☐ Rabeprazole
☐ Pantoprazole	☐ Lansoprazole	☐ Prilosec (RX)	☐ Vimovo
	☐ Nexium		

Strength: Dosage Instructions: Quantity: Days Supply:

Diagnosis:

- ☐ Barrett's esophagus (Please fax a copy of the scope results with the initial request)
- ☐ Erosive esophagitis (Please fax a copy of the scope results with the initial request)
- ☐ Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, and multiple endocrine adenomas).
- ☐ Recurrent peptic ulcer disease
- ☐ Symptomatic gastroesophageal reflux. Requests for PPIs exceeding one unit per day will be considered after documentation of a therapeutic trial and therapy failure with concomitant use of once daily PPI dosing and a bedtime dose of a histamine H2-receptor antagonist. Upon failure of the combination therapy, subsequent requests for PPIs exceeding one unit per day will be considered on a short term basis (up to 3 months). After the three month period, a retrial of the recommended once daily dosing will be required. A trial of the recommended once daily dosing will be required on an annual basis for those patients continuing to need doses beyond one unit per day.
- ☐ Active *Helicobacter pylori infection* (attach documentation). Requests for twice daily dosing will be considered for up to 14 days of treatment for an active infection.
- ☐ Other:

Trial Medications and Dates:

Medical or contraindication reason to override trial requirements:

Scope Performed? ☐ No ☐ Yes If yes, date of scope:

Reason for use of Non-Preferred drug requiring prior approval:

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Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.