

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueChoice® HealthPlan

Patient Information	
Name:	Insurance ID #:
Address:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is completed, please fax back to Caremark at 888-836-0730.

This fax machine is located in a HIPAA-compliant secure location.

Call Caremark at 800-294-5979 with any questions concerning prior authorization procedures.

*On behalf of BlueChoice HealthPlan, Caremark assists in the administration of this program.
Caremark is an independent company that administers prescription drug benefits.*

1. Is the physician one of the following medical specialists?
Gastroenterology, Pulmonology, ENT (ear, nose, and throat), Allergy
[If the answer to this question is yes, then no further questions are required.] Y N
2. Does the patient require more than 8 weeks of therapy?
[Comment: Up to 8 weeks of therapy are available without prior authorization.]
[If the answer to this question is no, then no further questions are required.] Y N
3. Does the patient have a diagnosis of a pathological hypersecretory condition (e.g., Zollinger-Ellison syndrome)?
[If the answer to this question is yes, then may skip to question 5.] Y N
4. Does the patient have a diagnosis of grade III or IV Erosive Esophagitis (Barrett's)? Y N
5. Does the patient require more than once daily dosing of PPI?
[If the answer to this question is no, then may skip to question 10.] Y N
6. Will the medication be used as part of an active H. pylori eradication regimen?
[If the answer to this question is no, then may skip to question 8.] Y N
7. Has the patient tested positive for *H. pylori*? Y N
8. Has the patient had a trial of the maximum PPI dosage on a once-daily basis?
(see Table 1) Y N

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM
BlueChoice® HealthPlan

- 9. Has patient remained symptomatic despite once-daily high dose PPI? [Y] [N]
10. Is the patient <= 11 years of age? [If the answer to this question is yes, then no further questions are required.] [Y] [N]
11. Does the patient have a history of intolerance, significant adverse reaction or non response to generic prescription PPIs or available OTC PPIs? [If the answer to this question is yes, then no further questions are required.] [Y] [N]
12. Would the physician be willing to prescribe generic omeprazole, pantoprazole, lansoprazole or an available OTC PPI? [Y] [N]

Comments: _____

Information on this form is accurate as of the date below.

Table with 2 columns: Prescriber's Signature, Date