

# PPI Step Therapy

## PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueChoice<sup>®</sup> 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. Does the patient have a documented contraindication to or a potential drug interaction (e.g., omeprazole and Plavix) with a prescription generic PPI, an OTC PPI or Nexium)?  
[If answer to this question is yes, then no further questions required.]  Y  N
2. Is the patient intolerant to or had a confirmed adverse event with a prescription generic PPI, an OTC PPI or Nexium?  
[If answer to this question is yes, then no further questions required.]  Y  N
3. Has the patient demonstrated an inadequate treatment response after at least a 30 day trial of a prescription generic PPI, an OTC PPI or Nexium?  Y  N

Comments: \_\_\_\_\_

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

Prescriber's Signature:	Date:
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