



Proton Pump Inhibitor PA Form

**Fax Completed Form to:
866-254-0761
For questions regarding this
Prior authorization, call
866-773-0695**

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving proton pump inhibitors must use Prilosec OTC, Prevacid 24HR, Omeprazole, or Pantoprazole as first line.

- *Note:**
- Prilosec OTC, Prevacid 24HR, Omeprazole and Pantoprazole may be prescribed WITHOUT prior authorization. Prilosec OTC and Prevacid 24HR are covered by Medicaid when prescribed by a physician.
 - Prior Authorization is NOT required for patients < 13 years of age.
 - Patients must use Prilosec OTC, Prevacid 24HR, omeprazole, or pantoprazole for a minimum of 14 days for the trial to be considered a failure. Patient preference does not constitute a failure.
 - Net cost to Medicaid: Prilosec OTC = Prevacid 24HR = Omeprazole = Pantoprazole <<< Lansoprazole << Aciphex << Nexium << Zegerid <<< Dexilant.

Part I: TO BE COMPLETED BY PRESCRIBER

RECIPIENT NAME:		RECIPIENT MEDICAID ID NUMBER:	
Recipient Date of birth: / /			
PRESCRIBER NAME:		PRESCRIBER MEDICAID ID NUMBER:	
Address:		Phone: ()	
City:		FAX: ()	
State:	Zip:		
REQUESTED DRUG: <input type="checkbox"/> Aciphex <input type="checkbox"/> Lansoprazole <input type="checkbox"/> Nexium <input type="checkbox"/> Zegerid <input type="checkbox"/> Dexilant		Requested Dosage: (must be completed) Diagnosis for this request:	
Qualifications for coverage:			
<input type="checkbox"/> Failed Prilosec OTC/Prevacid 24HR/Omeprazole/Pantoprazole therapy		Start Date:	Dose:
		End Date:	Frequency:
<input type="checkbox"/> Pregnancy – Due Date			
<input type="checkbox"/> Inability to take or tolerate oral tablets (must check a box)			
<input type="checkbox"/> Tube Fed <input type="checkbox"/> Requires soft food or liquid administration <input type="checkbox"/> Other (provide description)			
<input type="checkbox"/> Adverse reaction (attach FDA Medwatch form) to omeprazole/lansoprazole.			
<input type="checkbox"/> I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.			
Prescriber Signature:		Date:	

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Part III: FOR OFFICIAL USE ONLY

Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	