



**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 or Omeprazole as first line.

- \*Note:**
- Prilosec OTC and Omeprazole may be prescribed WITHOUT prior authorization. Prilosec OTC is covered by Medicaid when prescribed by a physician.
  - Prior Authorization is NOT required for patients < 13 years of age.
  - Patients must use Prilosec OTC or Omeprazole 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 = Omeprazole <<< Protonix < Prevacid << Aciphex < Prilosec RX << Nexium << Zegerid <<< Kapidex.

**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:		
<b>REQUESTED DRUG:</b> <input type="checkbox"/> Protonix <input type="checkbox"/> Aciphex <input type="checkbox"/> Prevacid <input type="checkbox"/> Nexium <input type="checkbox"/> Prilosec <input type="checkbox"/> Zegerid <input type="checkbox"/> Kapidex		<b>Requested Dosage:</b> (must be completed)  <b>Diagnosis for this request:</b>	
<b>Qualifications for coverage:</b>			
<input type="checkbox"/> Failed omeprazole 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.			
<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)	

