



PROTON PUMP INHIBITOR PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this
Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving proton pump inhibitors use **Prilosec OTC, omeprazole 20mg or lansoprazole** first line.

- Prilosec OTC, omeprazole 20mg, or lansoprazole may be prescribed **WITHOUT** prior authorization.
- Prior authorization is **NOT** required for patients < 13 years of age
- Patients must use Prilosec, omeprazole 20mg, or lansoprazole for a minimum of 14 days for the trial to be considered a failure. Patient preference does not constitute treatment failure.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy)

RECIPIENT NAME: Recipient Date of birth: / /	RECIPIENT MEDICAID ID NUMBER:
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Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy)

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:
City:	PHONE: () FAX: ()

Part III: TO BE COMPLETED BY PHYSICIAN

REQUESTED DRUG: <input type="checkbox"/> ACIPHEX <input type="checkbox"/> PREVPAC <input type="checkbox"/> NEXIUM <input type="checkbox"/> PRILOSEC RX <input type="checkbox"/> PREVACID <input type="checkbox"/> PROTONIX <input type="checkbox"/> PANTOPRAZOLE <input type="checkbox"/> ZEGERID <input type="checkbox"/> <input type="checkbox"/> KAPIDEX	Requested Dosage: (must be completed) Diagnosis: <input type="checkbox"/> GERD <input type="checkbox"/> Erosive esophagitis <input type="checkbox"/> H. pylori <input type="checkbox"/> Barrett's esophagitis <input type="checkbox"/> Hypersecretory conditions <input type="checkbox"/> Peptic ulcer <input type="checkbox"/> Duodenal ulcer
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Qualifications for coverage:

<input type="checkbox"/> Failed Prilosec OTC, omeprazole 20mg, or lansoprazole	Was Prilosec OTC/omeprazole/lansoprazole trial for at least 14 days? <input type="checkbox"/> YES <input type="checkbox"/> NO	Dose: Frequency:
<input type="checkbox"/> Adverse Reaction to Prilosec OTC/Omeprazole/Lansoprazole (attach FDA Medwatch form) or contraindicated (provide description below):		
<input type="checkbox"/> Inability to take or tolerate oral tablets (must check a box below): <input type="checkbox"/> Tube Fed <input type="checkbox"/> Requires soft food or liquid administration Other (provide description at right)		
Physician Signature:	Date:	

Part IV: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE:	FAX:
Part V: FOR OFFICIAL USE ONLY	
NDC#:	

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