Date ____________________

Client ____________________

PRIOR AUTH CRITERIA- PROTON PUMP INHIBITORS-PPI (GI/ULCER)

M.D. Last Name: ____________________ ***M.D. First Name:*** ____________________

Physician Phone: ____________________ ***Physician Fax:*** ____________________

Patient ____________________ ***ID#*** ____________________ ***DOB*** ______________

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

1. Please circle which agent is being requested:

STEP B	STEP C
• Nexium • Pantoprazole 40mg (generic) • Prevacid	• Aciphex • Pantoprazole 20mg (generic) • Kapidex • Protonix 20mg and 40mg (brand)

Strength requested: _________ **Dosage requested:** __________

****Note: For twice-daily dosing, please attach the EGD report, confirming a diagnosis of Atypical GERD.**
***Please note that if member is beginning therapy with a Proton Pump Inhibitor, the member's benefit will only cover generic Omeprazole, unless the member has already tried and failed generic Omeprazole.**

****Please Note that Step C drugs will not be approved unless all Step B drugs have been tried and failed**

2. Please provide the patient's diagnosis____________________.
3. **Attach chart notes** of member's failure on Prilosec, generic Omeprazole, or Prilosec OTC:
   Nature of Failure____________________.
4. **Attach chart notes** of member's failure on Nexium:
   Nature of Failure____________________.
5. **Attach chart notes** of member's failure on Pantoprazole 40mg (generic)
   Nature of Failure____________________.
6. **Attach chart notes** of member's failure on Prevacid
   Nature of Failure____________________.
7. Is the patient pregnant? Yes No

Physician Signature or name of person providing answers ____________________

Physician Comments ____________________

Send or Fax completed form to:
877-329-7279

RESTAT
P.O. BOX 758
WEST BEND. WI 53095

QUESTIONS PLEASE CALL:
877-526-9906