Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Proton Pump Inhibitors

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Florida at **1-855-799-2554**.
When conditions are met, we will authorize the coverage of Proton Pump Inhibitors.
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name

Aciphex (rabeprazole)	Aciphex Sprinkles (rabeprazole)	Dexilant (dexlansoprazole)
Esomeprazole Strontium	Nexium (esomeprazole)	Prevacid (lansoprazole)
Prilosec (omeprazole)	Protonix (pantroprazole)	Zegerid (omeprazole/bicarbonate)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Does the patient have a diagnosis of gastroesophageal reflux disease (GERD)? Y N
   [If no, then skip to question 6.]

2. Has the patient had an initial response to treatment with PPI therapy? Y N
   [If no, then no further questions.]

3. Patient has experienced recurrent symptoms (heartburn, regurgitation) since discontinuing PPI therapy? Y N
   [If no, then no further questions.]

4. Patient has documented history of esophagitis? Y N
   [If yes, then no further questions.]

5. Has the prescriber indicated the requested medication will be administered in the lowest effective dose, including possible intermittent or PRN therapy? Y N
   [No further questions.]

6. Is the patient at high risk of peptic ulcer disease due to concomitant drug therapy? Y N
   [If no, then no further questions.]

7. Does the patient require concomitant therapy with an NSAID and a cardioprotective dose of ASA (less the 325 mg per day)? Y N
   [If yes, then no further questions.]

8. Does the patient require concomitant therapy with ASA and an anticoagulant (including unfractionated heparin, LMWH, warfarin or a novel oral anticoagulant? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date