



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Proton Pump Inhibitors

Phone: 866-841-7659

Fax back to: 866-240-3712

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
Member ID Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Phone Number:	NPI:	PA PROMISe ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):	
Drug Name:	Strength:	
Quantity:	Refills:	
Directions:		
Diagnosis Code:	Diagnosis:	

Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. The member is prescribed the requested PPI for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication.

Yes

No

Q2. The member is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

Yes

No

Q3. For a non-preferred PPI, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred PPIs.

Yes

No

Q4. For a child under six years of age when a PPI has been prescribed for a total of four months or more in the preceding 180-day period, one of the following:

Has a chronic primary disease such as cystic fibrosis, cerebral palsy, Down syndrome, intellectual disability, or repaired esophageal atresia



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<input type="checkbox"/> Has documentation of a comprehensive evaluation and appropriate diagnostic testing confirming a diagnosis that requires chronic therapy
<input type="checkbox"/> Is being prescribed the requested drug by or in consultation with a gastroenterologist

Q5. For an OTC PPI for a dual-eligible beneficiary, both of the following:	
<input type="checkbox"/> a. Is not being prescribed the OTC PPI as part of a Medicare Part D plan utilization management program, including a step-therapy or prior authorization program	<input type="checkbox"/> b. Has a history of therapeutic failure of or a contraindication or an intolerance to the PPIs on the beneficiary's Medicare Part D plan formulary.

Q6. Additional Information:

Prescriber Signature

Date

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