United Healthcare Community Plan

Proton Pump Inhibitors (PPIs) - Washington
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

Patients receiving a PPI for more than 2 months during any 12-month period may be candidates for stepdown therapy. Prescribers should re-evaluate patients with a diagnosis of gastroesophageal reflux disease (GERD) with negative findings on endoscopy and discontinue the PPI.
For patients with certain concurrent medications or gastrointestinal conditions, PPIs may be covered for more than 2 months per year with a prior authorization.

ALL ADDITIONAL DOCUMENTATION REQUESTED IS REQUIRED

Please indicate client's diagnosis (check all that apply):

☐ **Gastroesophageal reflux disease (GERD):** Patients will be allowed only 2 months of PPI therapy during any 12-month period with a potential additional fill for tapering. See attached sheet for additional information and a sample taper plan.

☐ **Pathological gastric acid hypersecretion, e.g. Zollinger-Ellison Syndrome**
- Attach GI consultation note documenting diagnosis.

☐ **Barrett's esophagus**
- Attach clinical EGD report from within the last 5 years

☐ **Peptic ulcer disease**

☐ Duodenal ulcer:
- Attach EGD report from within last 12 months documenting diagnosis **AND**
- *H. pylori* test results (biopsy, breath, or stool test).

☐ Gastric ulcer:
- Attach EGD report from within last 60 days documenting diagnosis **AND**
- *H. pylori* test results (biopsy, breath, or stool test).

☐ **Eosinophilic esophagitis**
- Attach EGD report from within the last 12 months documenting diagnosis.

☐ **Esophageal stenosis/stricture or Schatzki ring**
- Attach EGD report documenting stenosis, stricture, or ring.

☐ **Erosive/ulcerative esophagitis**
- Attach EGD report from within last 16 months documenting LA classification **AND**
- *H. pylori* test results (biopsy, breath, or stool test).

☐ ***H. pylori* positive**
- Attach *H. pylori* test results (biopsy, breath, or stool test).

☐ **Other (Specify)** _____
- Attach all specialist notes and current labs supporting continued use of PPI.

Indicate any concurrent medications patient is currently taking (check all that apply):

☐ Nonsteroidal anti-inflammatory drug (NSAID). Specify drug: _____

☐ High-dose systemic corticosteroid. Specify drug: _____

☐ Antiplatelet or anticoagulant. Specify drug: _____
- List risk factors for GI bleed: _____

☐ Daily aspirin. Dose per day (mg): _____
- History of GI bleed in last 10 years? ☐ Yes ☐ No
  - If yes, attach EGD report from last 10 years documenting GI bleed.

☐ Bisphosphonate. Specify drug: _____
- Was it ingested with full glass of water, and patient remained upright afterward? ☐ Yes ☐ No

☐ Pancreatic enzyme. Specify drug: _____

☐ Cancer therapy. Specify regimen: _____

Expected PPI duration needed to tolerate cancer therapy: _____

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For requests over once daily dosing only:

Is patient increasing from once daily dosing to twice daily dosing? ☐ Yes ☐ No

- Has the patient experienced uncontrolled symptoms on once daily dosing? ☐ Yes ☐ No
- What was the duration of once daily dosing? _____

If patient is currently on twice daily dosing, has once daily dosing been tried? ☐ Yes ☐ No

- What was the duration the once daily dosing was tried? _____
- What was the outcome? _____

Prescriber signature	Prescriber specialty	Date