South Dakota Department of Social Services

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Proton Pump Inhibitor Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Barrett's esophagitis ❑ Erosive esophagitis ❑ Zollinger-Ellison Syndrome

❑ Other diagnosis: _____ ICD-10 Code(s): _____

For Aciphex Sprinkle, Konnovemp (omeprazole-bicarbonate), Nexium oral packet, Prevacid Solutab (lansoprazole orally disintegrating tablet [ODT]), Prilosec delayed release suspension pack, Protonix packet, and Zegerid oral packet (omeprazole/sodium bicarbonate oral packet) requests, answer the following:

Does the patient have a diagnosis which confirms a difficulty in swallowing? ❑ **Yes** ❑ **No**

For Dexilant, Nexium capsule (esomeprazole magnesium capsule), Prevpack oral pack (lansoprazole-amoxicillin-clarithromycin oral pack), Protonix tablet, and Zegerid capsule (omeprazole-sodium bicarbonate capsule) requests, answer the following:

Has the patient had a trial and failure (after a minimum of 14 days) in the past year with at least one of the following generics: Lansoprazole, omeprazole, pantoprazole, or rabeprazole? ❑ **Yes** ❑ **No**

Has the patient experienced an adverse reaction (must be documented on a MedWatch form), allergy or contraindication to **ALL** of the following: Lansoprazole, omeprazole, pantoprazole, and rabeprazole? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other:

_____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.