

## Prior Authorization Criteria for Proton Pump Inhibitors (PPI)

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Doctor: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Which PPI & dose are you requesting? (please select); \* Denotes preferred product

**Protonix\***

- 20 mg per day
- 40 mg per day

**Kapidex**

- 30 mg per day
- 60 mg per day

**Aciphex**

- 20 mg per day

**Nexium**

- 20 mg per day
- 40 mg per day

Please circle response below:

1. Does patient have the diagnosis of **GERD**? If yes, go to **A1**. If no, go to **2**.

A1. Most patients without alarm symptoms need to have tried and failed **high dose H<sub>2</sub> antagonist**:

- Has patient failed high dose H<sub>2</sub> antagonist? (Circle) YES OR NO.
- Medication name and strength tried (please select):
  - bidnizatidine 300 mg bid
  - famotidine 40 mg bid
  - none tried.
  - cimetidine 800 mg bid
  - ranitidine 300 mg bid
- Then, Proceed to **A2**.

A2. All Patients need to have tried and failed Prilosec OTC.

- Has patient failed Prilosec OTC? (Circle): YES or NO. Proceed to **B**.

B. Has patient had upper endoscopy to evaluate his or her disease? If yes, fax copy of EGD report with this request. If no, send to WHP.

2. Does patient have the diagnosis of **Barrett's esophagus, hypersecretory syndrome (e.g., Zollinger-Ellison Syndrome), upper gastro intestinal cancer or H. Pylori positive peptic ulcer (including stomach, duodenal or jejunal ulcers)**? If yes, send to WHP. If no, go to **3**.

3. Is the patient being prescribed PPI therapy for the **prevention of NSAID induced ulcers**? If yes, go to **A**. If no, send to WHP.

A. Is the patient at high risk for NSAID-induced GI adverse events? Please list circle risk factor, then send to WHP: age 60 or older; history of peptic ulcer or GI bleed; concomitant use of corticosteroids or anticoagulants; ARA functional class III or IV; other: \_\_\_\_\_.

Check box if this authorization is for GERD renewal. Please note that Upper endoscopy is recommended in patients with inadequate symptom relief on chronic PPI therapy.

Sent in by: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_