MC-Rx
Powered by ProCare Rx

Proton Pump Inhibitors (PPIs)
Aciphex®, Nexium®, Prevacid®, Prilosec®, Protonix®, Zegerid®, Dexilant®

Ticket #: ______________________ **Request Date:** ______________________ **Request Time:** ______________________

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of **PPIs**. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information

Patient Name:	Plan Name/Plan ID:	
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:

B. Physician Information

Physician Name:	Physician Address:	
Physician DEA #:	Physician Phone #:	Physician Fax #:
Drug Name and Strength:	QTY and Days Supply:	NDC # and GCN:

C. Pharmacy Information

Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:

D. Clinical Information (Please fill out the following information.)

1. Does the patient have one of the following diagnoses? (check all that apply) YES NO
   - ☐ Barret's esophagitis
   - ☐ Pathhological Hypersecretory Condtion
   - ☐ Zollinger-Ellison Syndrome
2. Has the patient had at least a 30-day history on any of the following PPI drugs? YES NO
   If YES, please check all that apply and indicated dates of therapy:
   - ☐ Aciphex: dates of therapy: ____________________
   - ☐ Prilosec: dates of therapy: ______________________
   - ☐ Dexilant: dates of therapy: ____________________
   - ☐ Protonix: dates of therapy: ______________________
   - ☐ Nexium: dates of therapy: _____________________
   - ☐ Zegrid: dates of therapy: _______________________
   - ☐ Prevacid: dates of therapy: ____________________
3. Does the patient have one of the following diagnoses? (check all that apply) YES NO
   - ☐ Duodenal Ulcer Maintenance
   - ☐ Recurrent Gastroesophageal Reflux Disease (GERD)
   - ☐ Benign Gastric Ulcer
   - ☐ History of Gastric Ulcers
   - ☐ Erosive Esophagitis
4. Does the patient have a diagnosis of H. pylori and is receiving concurrent antibiotic therapy [e.g. amoxicillin, clarithromycin, metronidazole, tetracycline, Levaquin® (at least 2 of 3)] with the PPI prescription? YES NO
5. Has the patient currently been on this medication? If YES, please indicate length of time: ________________________ YES NO

Authorized Medical Signature:	
Telephone:	**Date:**

<u>When Completed Return To</u>:

MC-Rx Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.

Prior authorization forms are reviewed at least annually and are available at www.MC-Rx.com. Medical Review Criteria are reviewed at least annually. Revised 5/2019