FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR PROTON PUMP INHIBITOR (PPI) ORALLY DISINTEGRATING TABLETS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Orally Disintegrating Tablets Completion Instructions, F-00433A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/subsystem/publications/forwardhealthcommunications.aspx?panel=Forms* for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Orally Disintegrating Tablets form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a PA request on the Portal, by fax, or by mail. Providers may call Provider Services at 800-947-9627 with questions.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number	3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name	5. Drug Strength
6. Date Prescription Written	7. Refills

8. Directions for Use

9. Name — Prescriber	10. National Provider Identifier (NPI) — Prescriber

11. Address — Prescriber (Street, City, State, ZIP+4 Code)

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION (Required for all PA requests.)

13. Diagnosis Code and Description

14. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with any dosage form of esomeprazole? ❑ Yes ❑ No

If yes, list the dates esomeprazole was taken. _____

Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

Continued

SECTION III — CLINICAL INFORMATION (Required for all PA requests.) (Continued)

15. Is there a clinically significant drug interaction between another drug the member is taking and esomeprazole? ❑ Yes ❑ No

    If yes, list the drug(s) and interaction(s) in the space provided.

16. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with any dosage form of omeprazole? ❑ Yes ❑ No

    If yes, list the dates omeprazole was taken. _____

    Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

17. Is there a clinically significant drug interaction between another drug the member is taking and omeprazole? ❑ Yes ❑ No

    If yes, list the drug(s) and interaction(s) in the space provided.

18. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with any dosage form of pantoprazole? (If the member is under 5 years old, check “N/A.") ❑ Yes ❑ No ❑ N/A

    If yes, list the dates pantoprazole was taken. _____

    Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

19. Is there a clinically significant drug interaction between another drug the member is taking and pantoprazole? (If the member is under 5 years old, check “N/A.") ❑ Yes ❑ No ❑ N/A

    If yes, list the drug(s) and interaction(s) in the space provided.

Continued

SECTION III — CLINICAL INFORMATION (Required for all PA requests.) (Continued)

20. Does the member have a medical condition(s) that prevents the use of PPI suspensions? ❑ Yes ❑ No

If yes, list the medical condition(s) and describe how the condition(s) prevents the member from using PPI suspensions in the space provided.

21. Is member preference the reason why the member is unable to take PPI suspensions? ❑ Yes ❑ No

SECTION IV — AUTHORIZED SIGNATURE

22. **SIGNATURE** — Prescriber	23. Date Signed

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

24. National Drug Code (11 Digits)	25. Days' Supply Requested (Up to 365 Days)

26. NPI

27. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)

28. Place of Service

29. Assigned PA Number

30. Grant Date	31. Expiration Date	32. Number of Days Approved

SECTION VI — ADDITIONAL INFORMATION

33. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.

Reset Form