



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Aciphex

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

<p>Patient Name:</p> <p>Member Number:</p> <p>Date of Birth:</p> <p>Group Number:</p> <p>Address:</p> <p>City, State, Zip:</p> <p>Member Phone:</p>	<p>Prescriber Name:</p> <p>Fax: Phone:</p> <p>Office Contact:</p> <p>NPI: State Lic ID:</p> <p>Address:</p> <p>City, State, Zip:</p>
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Drug Name: Expedited/Urgent

Directions:

Patient belongs to (please check one): HEALTH PARTNERS KIDZPARTNERS

<p>Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:</p>
<p>Q1. What is the requested duration of therapy?</p> <p style="margin-left: 20px;">12 months or less</p> <p style="margin-left: 20px;">Greater than 12 months</p>
<p>Q2. Is the patient greater than or equal to 12 years of age?</p> <p style="margin-left: 20px;">Yes No</p>
<p>Q3. Has the patient been diagnosed with erosive or ulcerative GERD?</p> <p style="margin-left: 20px;">Yes No</p>
<p>Q4. Is this being prescribed to maintain healing of erosive ulcerative GERD?</p> <p style="margin-left: 20px;">Yes No</p>
<p>Q5. Is this being prescribed to treat heartburn associated with symptomatic non-erosive GERD?</p> <p style="margin-left: 20px;">Yes No</p>
<p>Q6. Is this being prescribed for healing of duodenal ulcers?</p> <p style="margin-left: 20px;">Yes No</p>
<p>Q7. Is this being prescribed for Helicobacter pylori eradication to reduce the risk of duodenal ulcer recurrence?</p> <p style="margin-left: 20px;">Yes No</p>
<p>Q8. Is this being prescribed for long-term treatment of pathological hypersecretory conditions, including Zollinger-Ellison syndrome?</p> <p style="margin-left: 20px;">Yes No</p>
<p>Q9. Has the patient tried and failed omeprazole (up to 40 mg per day)?</p> <p style="margin-left: 20px;">Yes No</p>
<p>Q10. Has the patient tried and failed pantoprazole?</p> <p style="margin-left: 20px;">Yes No</p>



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Patient Name:

Prescriber Name:

Q11. Comments:

Physician Signature

Date