



**PRIOR AUTHORIZATION REQUEST FORM**

EOC ID:

Dexilant

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.**

<b>Patient Name:</b> Member Number: Date of Birth: Group Number: Address: City, State, Zip: Member Phone:	<b>Prescriber Name:</b> Fax: <span style="float:right">Phone:</span> Office Contact: NPI: <span style="float:right">State Lic ID:</span> Address: City, State, Zip:
---	--

Drug Name: Expedited/Urgent

Directions:

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

<b>Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:</b>
Q1. What is the requested duration of therapy? 12 months or less Greater than 12 months
Q2. Is the patient greater than or equal to 18 years of age? Yes      No
Q3. Has the patient been diagnosed with erosive esophagitis? Yes      No
Q4. Is this being prescribed to treat erosive esophagitis or to maintain healing of erosive esophagitis? Yes      No
Q5. Is this being prescribed to treat heartburn associated with symptomatic non-erosive GERD? Yes      No
Q6. Has the patient tried and failed omeprazole (up to 40 mg per day)? Yes      No
Q7. Has the patient tried and failed pantoprazole? Yes      No
Q8. Comments:

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Date**