Print Reset

AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

PROTON PUMP INHIBITORS (PPIs)

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Preferred PPIs: Omeprazole Rx, Pantoprazole, and Protonix susp (no SA required for short-term use; less than 90 days). All PPIs (preferred and non-preferred) after 90 days of utilization MUST meet the clinical service authorization criteria for continued use.

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

1. Request type.
   ☐ Initial ☐ Renewal
   Note: PDL criteria must be met first before a non-preferred PPI may be approved. *Initial requests* may be authorized for **12 weeks only**. *Renewal requests for both preferred and non-preferred PPI usage for greater than 3 months* may be allowed for 1 year **only** if one of the following exceptions has been met: member is under the care of a Gastroenterologist **or** member has a diagnosis of **active** GI Bleed, Erosive Esophagitis, Gastroesophageal Reflux Disease, Pathological Hypersecretory Syndrome, Unhealed Gastric, Duodenal or Peptic Ulcer, Barrett's Esophagus or Zollinger-Ellison Syndrome.
2. Has the member had a therapeutic failure of no less than a 3-month trial of at least **two** preferred PPIs?
   ☐ Yes ☐ No
   a. If YES, list medications:
      Drug 1: _____ Strength: _____ Start Date: _____
      Drug 2: _____ Strength: _____ Start Date: _____
      Drug 3: _____ Strength: _____ Start Date: _____
   b. If **No**, document compelling details: _____
      _____
3. Has this member seen a Gastroenterologist?
   ☐ Yes ☐ No *If **Yes**, document name:* _____
4. Does this member have one of the following conditions?

a. GI Bleeds	☐ Yes	☐ No
b. Zollinger-Ellison Syndrome	☐ Yes	☐ No
c. Gastroesophageal Reflux Disease	☐ Yes	☐ No
d. Pathological Hypersecretory Syndrome	☐ Yes	☐ No
e. Unhealed Gastric, Duodenal or Peptic Ulcer	☐ Yes	☐ No
f. Barrett's Esophagus	☐ Yes	☐ No
g. Erosive Esophagitis	☐ Yes	☐ No

5. **Medical Necessity** (Provide clinical evidence that the preferred agent(s) will not provide adequate benefit):
   _____

_____ _____

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.