

Network Health

Proton Pump Inhibitors Prior Authorization Request

Medication Request Form (MRF)

FAX TO: (877) 501-1059

c/o MedImpact Healthcare Systems, Inc.

Attn: Prior Authorization Department

10680 Treena Street, Suite 500, San Diego, CA 92131 - Phone: 1-800-788-2949

**Aciphex, Dexilant (Kapidex),
Lansoprazole RX, Nexium,
Omeprazole 40mg, Pantoprazole,
Zegerid, Prevacid RX, Prilosec
RX, Protonix**

Instructions:

This form is to be used by participating providers to obtain coverage for the drugs listed above, which require prior authorization. Please complete this form and fax it to MedImpact Healthcare Systems, Inc. at (877) 501-1059. If you have any questions regarding this process, please contact MedImpact's Customer Service at (800) 788-2949.

***** ONLY COMPLETED FORMS CAN BE PROCESSED *****

Member/Provider Information:

Member's Name:	Prescriber's Name:
Member's Network Health ID #:	Prescriber's Specialty:
Member's DOB (mm-dd-yy):	DEA #(Required): _____ NPI #: _____
Pharmacy used by Member:	Prescriber's Telephone Number/ Contact Name:
Pharmacy (Area Code) Telephone Number:	Prescriber's (Area Code) Fax Number:

Clinical Information:

<p>Requested Drug: (Note: omeprazole OTC , omeprazole RX 10mg & 20mg and Lansoprazole OTC do not require prior authorization)</p> <p> <input type="checkbox"/> Aciphex <input type="checkbox"/> Dexilant (Kapidex) <input type="checkbox"/> Lansoprazole RX <input type="checkbox"/> Nexium <input type="checkbox"/> Omeprazole, Rx 40mg <input type="checkbox"/> Pantoprazole <input type="checkbox"/> Zegerid </p> <p>_____</p> <p> <input type="checkbox"/> Prevacid RX Brand Name <input type="checkbox"/> Prilosec Brand Name <input type="checkbox"/> Protonix Brand Name </p>
Dose and Quantity Requested:
Documentation of Medical Necessity (please check all that apply):
<p>1. Please indicate if the patient has had previous trials with generic agents or if the agent is contraindicated (check all that apply, the reason for discontinuation or contraindication):</p> <p style="text-align: center;">Reason for discontinuation or contraindication:</p> <p> <input type="checkbox"/> lansoprazole RX or OTC _____ <input type="checkbox"/> omeprazole Rx or OTC _____ <input type="checkbox"/> pantoprazole _____ </p> <p>2. For OMEPRAZOLE 40mg requests only: What is the reason member cannot take 2 x 20mg capsules? _____</p> <p>3. For BRAND NAME Requests: Justification why generic cannot be used. _____</p>

Request for expedited review (72 hours): By checking this box, I certify that applying the standard review time frame may seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

SIGNATURE

I CERTIFY THAT THE INFORMATION PROVIDED IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE, AND I UNDERSTAND THAT ANY FALSIFICATION, OMISSION, OR CONCEALMENT OF MATERIAL FACT MAY SUBJECT ME TO CIVIL OR CRIMINAL LIABILITY.

Prescriber's Signature (STAMP NOT ACCEPTED)

Date

DO NOT WRITE IN SHADED AREAS FOR INTERNAL USE ONLY
Contacted:
Provider:
Pharmacy:
Patient:

DO NOT WRITE IN SHADED AREAS FOR INTERNAL USE ONLY
Approved:
Denied:
Returned:
PA #