Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Zegerid

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Zegerid.

Drug Name (select from list of drugs shown)

Omeprazole-Sod Bicarbonate	Zegerid (omeprazole-sodium bicarbonate)	Zegerid Capsules (omeprazole-sodium bicarbonate)
Zegerid Oral Pkt (omeprazole-sodium bicarbonate)		

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Has the patient experienced an inadequate treatment response, intolerance, or contraindication to THREE generic proton pump inhibitors?	Y N
2.	Is the requested drug being prescribed for the treatment of gastroesophageal reflux disease (GERD) OR duodenal ulcer OR gastric ulcer?	Y N

[If yes, then no further questions.]

3.	Is the requested drug being prescribed for the maintenance of healing of erosive esophagitis?	Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date