Prior Authorization Criteria Form

CVS/CAREMARK FAX FORM

Proton Pump Inhibitors Post Limit

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 **1-888-414-3125** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Proton Pump Inhibitors Post Limit.

Drug Name (specify drug) ______________________________

Patient Information

Patient Name: ____________________
Patient ID: ____________________
Patient Group No.: ____________________
Patient DOB: ____________________

Prescribing Physician

Physician Name: ____________________
Physician Phone: ____________________
Physician Fax: ____________________
Physician Address: ____________________
City, State, Zip: ____________________

Diagnosis: ____________________ **ICD Code:** ____________________

Please circle the appropriate answer for each applicable question.

1. Does the patient have the diagnosis of Barrett's esophagus as confirmed by biopsy? Y N
   [If the answer to this question is yes, then no further questions required.]
2. Does the patient have the diagnosis of a hypersecretory syndrome, such as Zollinger-Ellison syndrome confirmed with a diagnostic test Y N
   (examples include: fasting serum gastrin, basal 1 hour acid output, secretin stimulation test)?
   [If the answer to this question is yes, then no further questions required.]
3. Does the patient have the diagnosis of endoscopically verified peptic ulcer disease (duodenal or gastric)? Y N
   [If the answer to this question is yes, then no further questions required.]
4. Does the patient require chronic NSAID therapy? Y N
   [If the answer to this question is no, then skip to question 6.]
5. Is the patient at high risk for GI adverse events? Y N
   (risk factors for serious GI adverse events include, but are not limited to, the following: history of peptic ulcer disease and/or gastrointestinal bleeding, treatment with oral corticosteroids, treatment with anticoagulants, poor general health status, or advanced age)
   [If the answer to this question is yes, no further questions required.]
6. Does the patient have the diagnosis of chronic gastroesophageal reflux disease (GERD)? Y N
   [If the answer to this question is no, no further questions required.]
7. Does the patient have frequent and severe symptoms of GERD Y N

(examples include: heartburn, regurgitation)?

[If the answer to this question is yes, then no further questions required.]

8. Does the patient have atypical symptoms or complications of GERD Y N

   (examples include: dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, erosive esophagitis, or esophageal stricture)?

   [If the answer to this question is yes, no further questions required.]

9. Were the patient's symptoms inadequately controlled with histamine2-receptor antagonists (H2RAs)? Y N

   (e.g., Pepcid, Zantac, Tagamet, Axid)

Comments: ____________________

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

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Prescriber (Or Authorized) Signature and Date