

Unison Health Plan Pharmacy Department
Proton Pump Inhibitor (PPI) Request Worksheet
 Please complete and return via fax to 412-457-1328 or 866-639-7785



PATIENT NAME _____

D.O.B. ___/___/___ **MEMBER ID#** _____ **DURATION** _____

DRUG REQUESTED: (Circle One) **PANTOPRAZOLE (PROTONIX)** **PREVACID** **Other:** _____

DOSAGE and Sig. _____ **FAX ATTENTION:** _____

PHYSICIAN (PLEASE PRINT) _____ **PH#** () _____ **FAX#** () _____

PHYSICIAN ADDRESS _____

***Please Note:** ALL are required fields above
 << Additional Drug Specific forms are available at UnisonHealthPlan.com >>

BACKGROUND INFORMATION RELEVANT TO THE REQUESTED MEDICATION
 Please complete only those sections that are relevant to this specific patient.

_____ **1. Patient has a diagnosis that warrants therapy in excess of 90 days (circle one):**
 (a) Zollinger Ellison Syndrome (b) Barrett's esophagitis (c) multiple endocrine adenomas
 (d) systemic mastocytosis (e) other _____

_____ **2. Patient has a history of receiving a chronic medication that can increase the patient's risk for GI ulceration or bleed thus warranting therapy in excess of 90 days (circle one):**
 (a) NSAIDs: Drug name _____ Date of initial RX _____ Last date of fill _____
 (b) Oral Drug name _____ Date of initial RX _____ Last date of fill _____
 Corticosteroids:
 (c) Anticoagulant: Drug name _____ Date of initial RX _____ Last date of fill _____

_____ **3. Patient has a history of one of the following clinical presentations which warrants therapy in excess of 90 days (circle one):**
 (a) Currently unstable with GI symptoms of gastritis, esophagitis, duodenitis, or GERD
 (b) Hematemesis, GI bleeds, or esophageal varices
 (c) COPD or asthma reflux exacerbations as a result of GERD
 (d) Hiatal hernia

_____ **4. Patient has had a documented attempt at step down therapy within the past six months, following three months of PPI therapy, to an H₂-Receptor Antagonist (H₂RA) such as ranitidine or cimetidine, with a relapse in symptoms thus warranting therapy in excess of 90 days (please complete):**
 Date of PPI discontinuation _____ Agent used in step down _____

_____ **5. Patient has another clinical reason which warrants therapy in excess of 90 days as follows: (Attach additional sheets if necessary.)**

****Patient requires BID therapy (please provide reason):** _____
 (Attach additional sheets if necessary.)

The purpose of this worksheet is to provide complete information regarding the physician's request for a non-formulary or prior authorization medication. It will be reviewed and notification of approval or denial will be given within 24 hours. Thank you.

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