State of Maine Department of Health & Human Services
MaineCare/MEDEL Prior Authorization Form
PROTON PUMP INHIBITORS

Phone: 1-888-445-0497 **www.mainecarepdl.org** Fax: 1-888-879-6938

Member ID #: |__|__|__|__|__|__|__|__|__|__| (NOT MEDICARE NUMBER) Patient Name: _____ DOB: _____

Patient Address:_____

Provider DEA: |__|__|__|__|__|__|__|__|__| Provider NPI: __|__|__|__|__|__|__|__|__|__|

Provider Name:_____ Phone:_____

Provider Address:_____ Fax:_____

Pharmacy Name:_____Rx Address:_____Rx phone:_____

Provider must fill all information above. It must be legible, correct and complete or form will be returned.

(Pharmacy use only): NPI: __|__|__|__|__|__|__|__|__|__| NABP: |__|__|__|__|__|__|__| NDC: |__|__|__|__|__|__|__|__|__|__|__|

All preferred products must be tried and failed before a non-preferred will be considered. Prior authorization is NOT required for Prevacid SoluTabs for children age 8 or younger for the first 60 days of therapy.

Non-Preferred (PA required)

Nexium[6]	☐	**Dexilant[8]**	☐	**Prevacid SoluTabs[8] (8 or younger)**	☐
Prilosec (OTC)[7]	☐	**Prilosec (RX)[8]**	☐	**Omep-Sod-Bicarb[8]**	☐
Aciphex[7]	☐	**Protonix[8]**	☐	**Omeprazole-Magnesium[8]**	☐
		Prevacid[8]	☐		

Strength	Dosage Instructions	Quantity	Days Supply	Refills
_____	_____	_____	_____	1 2 3 4 5

Diagnosis:

- ☐ **Barrett's esophagus**
- ☐ **Erosive esophagitis**
- ☐ **Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, and multiple endocrine adenomas). Recurrent peptic ulcer disease after documentation of previous trials and therapy failure with at least one histamine H2-receptor antagonist at full therapeutic doses and with documentation of either failure of *Helicobacter pylori* treatment or a negative *Helicobacter pylori* test result.**
- ☐ **Symptomatic gastroesophageal reflux after documentation of previous trials and therapy failure with at least one histamine H2-receptor antagonist at full therapeutic doses. H2-receptor antagonist trial must have been in the last 12 months.**
- ☐ **Other: _____**

Trial Medication: _____ Trial Date From: _____ To: _____
Medical or contraindication reason to override trial requirements: _____
Scope Performed? ☐ No ☐ Yes If yes, date of scope: _____
Reason for use of Non-Preferred drug requiring prior approval: _____
Patient is 9 years of age and cannot tolerate a solid oral dosage form? ☐ No ☐ Yes

Attach lab results and other documentation as necessary.

Pursuant to Chapter I, Section 80, The Department regards adequate clinical records as essential for the delivery of quality care, such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessary, meets the MaineCare criteria for prior authorization, does not exceed the medical needs of the member and is supported in your medical records.

Provider Signature: _____ Date of Submission: _____
***MUST MATCH PROVIDER LISTED ABOVE**