

PANTOPRAZOLE

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross[®] BlueShield[®] of South Carolina

Patient Information	
Name:	Insurance ID #:
Address:	Birthdate:

Provider Information	
Physician Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is completed, please fax to Caremark at 888-866-0730

This fax machine is located in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures.

- Does the patient have the diagnosis of Barrett's esophagus as confirmed by biopsy?
[If the answer to this question is yes, no further questions are required.] Y N
- Does the patient have a diagnosis of a hypersecretory syndrome, such as Zollinger-Ellison syndrome as confirmed with a diagnostic test?
[If the answer to this question is yes, no further questions are required.] Y N
- Does the patient have the diagnosis of endoscopically verified peptic ulcer disease (duodenal or gastric)?
[If the answer to question is no, skip to question 6.] Y N
- Was the patient tested for H.pylori?
[If the answer to this question is no, no further questions are required.] Y N
- Was the H.pylori test positive?
[No further questions are required.] Y N
- Does the patient require chronic NSAID therapy?
[If the answer to this question is no, skip to question 8.] Y N

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7. Is the patient at high risk for GI adverse events?
• (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 advance age)
[If the answer to this question is yes, no further questions are required.] Y N
8. Does the patient have the diagnosis of chronic gastroesophageal reflux disease (GERD)?
[If the answer to this question is no, no further questions are required.] Y N
9. Does the patient have frequent and severe symptoms of GERD?
[If the answer to question is yes, no further questions are required.] Y N
10. Does the patient have atypical symptoms or complications of GERD?
[If the answer to this question is yes, no further questions are required.] Y N
11. Did the patient have at least a 30-day trial of a histamine2-receptor antagonist (H2RA)?
(e.g., Pepcid, Zantac, Tagamet, Axid)
[If the answer to this question is no, no further questions are required.] Y N
12. Were the patient's symptoms inadequately controlled with the histamine2-receptor antagonist
(H2RA)? Y N

Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature:	Date:
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