DEXILANT

MEDICARE ADVANTAGE PRIOR AUTHORIZATION REQUEST FORM
BlueCross® BlueShield® of South Carolina

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

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

When this form is complete, please fax to Caremark at 888-836-0730.

This fax machine is 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 800-294-5979 with any questions concerning prior authorization procedures.

1. Does the patient require more than 90 days of therapy? Y N
   [If the answer to this question is no, no prior authorization is required for up to 90 days of therapy per 365 days.]
2. Does the patient have a diagnosis of Barrett's esophagus as confirmed by biopsy? Y N
   [If the answer to this question is yes, no further questions are required.]
3. Does the patient have the diagnosis of hypersecretory syndrome, such as Zollinger-Ellison syndrome, confirmed with a diagnostic test (for tech clarification only, examples might be: fasting serum gastrin, basal one-hour acid output, secretin stimulation test)? Y N
   [If the answer to question is yes, no further questions are required.]
4. 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, no further questions are required.]
5. Does the patient require chronic NSAID therapy? Y N
   [If the answer to this question is no, skip to question 7.]

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6. 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 advanced age.) [If the answer to this question is yes, no further questions are required.] ☐ Y ☐ N
7. 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
8. Does the patient have frequent and severe symptoms of GERD (for tech clarification only, examples might be: heartburn, regurgitation)? [If the answer to this question is yes, no further questions are required.] ☐ Y ☐ N
9. Does the patient have atypical symptoms or complications of GERD? [If the answer to question is yes, no further questions are required.] ☐ Y ☐ N
10. Were the patient's symptoms inadequately controlled with the histamine2-receptor antagonist (H2RA) (e.g., Pepcid, Zantac, tagamet, Axid)? ☐ Y ☐ N

Comments: ______________________________

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

Prescriber's Signature:	**Date:**

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