

# PREVACID (lansoprazole) QUANTITY MANAGEMENT

## PRIOR AUTHORIZATION REQUEST FORM

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark's prior authorization department at 1-888-836-0730. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures. Members should call Caremark Customer Care at 1-888-963-7290 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

**Please circle the appropriate answer for each applicable question (Y for Yes, N for No).**

- Is the patient under the age of 5? Y    N  
[If the answer to this question is no, then skip to question 6.]
- Is the prescription request for Prevacid?  Y    N  
[If the answer to this question is no, then skip to question 6.]
- Is the prescription request for Prevacid ODT (orally disintegrating tablets)? Y    N  
[If the answer to this question is yes, then skip to question 5.]
- Is the prescription being compounded? Y    N
- Is the patient unable to take another available proton pump inhibitor (PPI) dosage form? Y    N  
[No further questions are required.]
- Is the prescriber one of the following medical specialists? Y    N  
Gastroenterologist, Pulmonologist, ENT (ear, nose, and throat) Specialist, Allergy Specialist  
[If the answer to this question is yes, then no further questions are required.]

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7. Does the patient have a diagnosis of a pathological hypersecretory condition (e.g., Zollinger-Ellison syndrome)? Y N  
[If the answer to this question is yes, then no further questions are required.]
8. Does the patient have a diagnosis of grade III or IV Erosive Esophagitis (Barrett's)? Y N  
[If the answer to this question is yes, then no further questions are required.]
9. Has the patient had a trial of the maximum PPI dosage on a once-daily basis? Y N  
AcipHex (rabeprazole) 20mg, Dexilant (dexlansoprazole) 60mg, Nexium (esomeprazole) 40mg, Prevacid (lansoprazole) 30mg, Prilosec (omeprazole) 40mg, Protonix (pantoprazole) 40mg, Zegerid (omeprazole/sodium bicarbonate) 40mg
10. Has patient remained symptomatic despite once-daily high dose PPI? Y N  
[If the answer to this question is yes, then no further questions are required.]
11. Will the PPI be used as part of an active H. pylori eradication regimen? Y N
12. Has the patient tested positive for H. pylori? Y N
13. No further questions required.

### Comments:

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

**Prescriber (or Authorized) Signature and Date:**

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