Print Reset

Alaska Medicaid

Proton Pump Inhibitor (PPI)

Twice Daily Dosing Prior Authorization Form

Non-Preferred PPIs must meet diagnosis criteria before being approved for daily or twice daily dosing.

This form may also be used for requests to exceed the maximum allowed units.

Form available on Alaska Medicaid's Medication Prior Authorization website

Fax this form to (888) 603-7696

This authorization request does not ensure eligibility and is not a guarantee of payment. Please verify Medicaid eligibility before completing this form. Incomplete requests will be denied until all required information is received.

Request Date: _____

REQUESTOR INFORMATION

Requestor Name: _____ Title: _____

MEMBER INFORMATION

Last Name: _____ First Name: _____

Member ID #: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female Member Phone: _____

PRESCRIBER INFORMATION

Last Name: _____ First Name: _____

Prescriber NPI: _____ Specialty: _____

Prescriber Phone: _____ Prescriber Fax: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

DRUG INFORMATION

Drug Name: _____ NDC: _____

Drug Strength: _____ Dosage Form: _____

Dosage Schedule: _____ Quantity: _____ Day Supply: _____

Alaska Medicaid PPI BID Dosing Prior Authorization Form

Last Name: _____ First Name: _____

CLINICAL INFORMATION

Primary diagnosis: _____

Other diagnoses: _____

Note: Recipients must have a trial of one dose per day before twice daily regimen will be approved along with proper clinical documentation. Certain diagnoses will be exempt from a trial period.

1. Has dosing been maximized to the highest strength available for this medication?
   ☐ Yes ☐ No *If YES, prescriber must provide medical rationale for BID dosing:*

2. Anticipated Duration of BID therapy: _____

3. Which non-pharmacologic treatments along with the use of PPI medication have been tried and failed?
   ☐ Weight loss ☐ Head of bed elevation ☐ Avoiding late evening meals

   Cessation of:
   ☐ Alcohol ☐ Caffeine ☐ Carbonated beverages
   ☐ Chocolate ☐ Citrus products ☐ Tobacco products
   ☐ Spicy foods

4. Please provide dates of trial and detail the patient's treatment failure on QD dosing:

☐ Attachments

Attestation: I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Alaska Medicaid.

Prescriber Signature: _____ **Date:** _____

Magellan Medicaid Administration, PA Unit
14100 Magellan Plaza
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Phone: (800) 331-4475

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