US Family Health Plan
Prior Authorization Request Form for
Proton Pump Inhibitors: lansoprazole capsules **(Prevacid),** omeprazole/sodium bicarbonate capsules **(Zegerid)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

NO prior authorization is required for the preferred proton pump inhibitors [PPIs] omeprazole capsules (Prilosec), and pantoprazole tablets (Protonix). Lansoprazole (Prevacid, generics), omeprazole/sodium bicarbonate (Zegerid, generics) are non-formulary and non-preferred PPIs and also require a prior authorization.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Does the prescriber acknowledge that omeprazole capsules and pantoprazole tablets are the Department of Defense's preferred Proton Pump Inhibitors?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the prescriber acknowledge that omeprazole capsules and pantoprazole tablets are available without a prior authorization?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have a contraindication or has the patient had an inadequate response or adverse reaction to omeprazole?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a contraindication or has the patient had an inadequate response or adverse reaction to pantoprazole?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a contraindication or has the patient had an inadequate response or adverse reaction to esomeprazole?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the patient have a contraindication or has the patient had an inadequate response or adverse reaction to rabeprazole?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[27 November 2019]