USFHP Prior Authorization Request Form for **Proton Pump Inhibitors:** lansoprazole ODT (**Prevacid Solutab**), omeprazole/sodium bicarbonate packets for suspension **(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.

The completed form may be faxed to 855-273-5735

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

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Prior authorization is not required for patients younger than 18 years of age.

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 provider acknowledge that omeprazole, lansoprazole capsules and pantoprazole tablets and capsules are Uniform Formulary and do not require prior authorization?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the provider acknowledge that omeprazole, esomeprazole, and pantoprazole packets for suspension and rabeprazole sprinkles are Uniform Formulary and do not require prior authorization?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**

3. Please provide patient-specific clinical rationale of why the patient cannot take ALL alternative PPI agents below.

omeprazole capsules: _____

lansoprazole capsules: _____

omeprazole packets: _____

pantoprazole tablets: _____

pantoprazole packets: _____

esomeprazole capsules: _____

esomeprazole packets: _____

rabeprazole tablets: _____

rabeprazole sprinkles: _____

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

_____ _____

Prescriber Signature Date