

**PROTON PUMP INHIBITORS
PREAUTHORIZATION
PHYSICIAN FAX FORM**



The following documentation is **REQUIRED** for preauthorization. Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross and Blue Shield of Nebraska website at www.bcbsne.com
Please allow a minimum of 3-5 business days for review.

Today's Date: _____

PATIENT INFORMATION

Patient Name (First):	Last:	M.I.:	DOB (mm/dd/yyyy):	Telephone Number:
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INSURANCE INFORMATION

BCBS ID Number:	Group Number:
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PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician UPIN#:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:			
City, State, Zip:	Phone #:	Secure Fax #:		

PREAUTHORIZATION INFORMATION

MEDICATION REQUESTED (check one)	<input type="checkbox"/> KAPIDEX™	<input type="checkbox"/> NEXIUM®	<input type="checkbox"/> PRILOSEC®	<input type="checkbox"/> PREVACID®	<input type="checkbox"/> PROTONIX®	<input type="checkbox"/> ZEGERID®
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1. Patient's diagnosis to be treated with requested medication _____

2. Within the past 12 months, has the patient tried each of these formulary PPI agents: Aciphex® YES NO
 generic pantoprazole YES NO
 generic omeprazole YES NO

3. Does the patient have contraindications to Aciphex®, generic pantoprazole or generic omeprazole? YES NO
 If yes, please describe which agent(s) and what the contraindications are _____

4. Are there other clinical considerations that would require a non-formulary PPI agent? _____

Please include any additional clinical information that should be considered for this review _____

Please fax or mail this form to:
 Blue Cross and Blue Shield of Nebraska
 Pharmacy Department - UM
 7261 Mercy Road
 Omaha, NE 68180-0001
Toll Free Fax: 877-232-6726
Phone: 877-999-2374

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