# SCRIPTGUIDERX REQUEST FOR PRIOR AUTHORIZATION
## PROTON PUMP INHIBITORS

**Prescribing Physician:**

**Name:**______________________________
First Last

**Direct Phone #:** (_ _ _) ________________

**Fax #:** (_ _ _) ______________________

**Physician specialty:** ________________

**Patient:**

**Name:**_______________________________________
First Last

**ID#:** __________________________________________

**Phone #:** ______________________**Client:**__________

**Birth Date:** _ _ - _ _ - _ _ _ _ **Sex:** ☐ **Female** ☐ **Male**

**Name and title of person completing form (please print):** ________________________________________

**Drug name:** **Strength:** **Administration Schedule:** **Length of Therapy:** **Quantity Requested:**

_________________________________________________________________________________________

**Has patient been on this drug and, if yes, for how long at this dosage?** ___________________________

**Patient's diagnosis requiring the use of this medication:** __________________________________________

**Please provide clinical documentation why patient is on twice a day dosing. If the diagnosis is GERD, the FDA approved and accepted prescribing guidelines for GERD is QD dosing. For BID dosing to be considered include documentation of failed QD dosing and the results of a recent EGD.**

**1. Previous history of a medical condition, allergies or other pertinent medical information that necessitates the use of this medication BID:**
___________________________________________________________________________________________

**2. Has the patient been seen by any other provider for this condition?** ☐ **Yes** ☐ **No**
**If so, what was the prescriber's specialty?** __________________________________________

**3. Previous non-prior authorized and prior authorized medications tried and failed for this condition:**

| Name of medication | Reason for failure | Date: |
|---|---|---|
| ____________________________ | ______________________________________ | _ _/ _ _/ _ _ _ _ |
| ____________________________ | ______________________________________ | _ _/ _ _/ _ _ _ _ |
| ____________________________ | ______________________________________ | _ _/ _ _/ _ _ _ _ |

**4. Pertinent laboratory test or procedure: (if applicable)**

| Procedure: | Findings: | Date: |
|---|---|---|
| ____________________________ | ______________________________________ | _ _/ _ _/ _ _ _ _ |
| ____________________________ | ______________________________________ | _ _/ _ _/ _ _ _ _ |
| ____________________________ | ______________________________________ | _ _/ _ _/ _ _ _ _ |

**Fax Request to: ScriptGuideRX @ 313-264-0985**

**For ScriptGuideRX use only**

Date Received:

Date Completed:

Decision (all authorizations are pending valid eligibility):