restat
A Dohmen Company

Date _____

PRIOR AUTH CRITERIA – Aciphex® - PPI (GI/ULCER)

M.D. Last Name: _____ ***M.D. First Name:*** _____

Physician Phone: _____ ***Physician Fax:*** _____

Patient _____ ***ID#*** _____ ***DOB*** _____

****FAILURE TO COMPLETE THE FORM MAY RESULT IN AN AUTOMATIC DENIAL****

1. Please indicate patient's diagnosis:

- ☐ Barrett's Esophagus **(attach EGD report)**
- ☐ Errosive Esophagitis **(attach EGD report)**
- ☐ Esophageal Stricture **(attach EGD report)**
- ☐ Gastritis
- ☐ GERD
- ☐ Laryngopharyngeal reflux
- ☐ Schatzki's Ring **(attach EGD report)**
- ☐ Zollinger-Ellison Syndrome **(attach EGD report)**
- ☐ Other (please specify): _____

2. Is the patient currently on Plavix®? Yes No

3. Is the patient pregnant? Yes No

4. Provide the dose and dates of trial and failure of **Prilosec® or generic omeprazole**:

_____

5. Provide the dose and dates of trial and failure of **generic lansoprazole (Prevacid®) or generic pantoprazole (Protonix®)**:

_____

6. Provide the dose and dates of trial and failure of **Nexium®**:

_____

7. Provide the dose and dates of trial and failure of **Dexilant®**:

_____

8. Provide the clinical rationale for use of the requested drug if the above medications have not been tried in the past:

_____

9. Dose requested: _____

10. **Physician Signature or name of person providing answers** _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

RESTAT
11900 W. Lake Park Dr.
Milwaukee, WI 53224
www.restat.com

QUESTIONS PLEASE CALL:
877-526-9906