

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:

- |  |  |
|--|--|
| <input type="checkbox"/> Barrett's Esophagus ( <b>attach EGD report</b> )  | <input type="checkbox"/> Laryngopharyngeal reflux                                |
| <input type="checkbox"/> Erosive Esophagitis ( <b>attach EGD report</b> )  | <input type="checkbox"/> Schatzki's Ring ( <b>attach EGD report</b> )            |
| <input type="checkbox"/> Esophageal Stricture ( <b>attach EGD report</b> ) | <input type="checkbox"/> Zollinger-Ellison Syndrome ( <b>attach EGD report</b> ) |
| <input type="checkbox"/> Gastritis   | <input type="checkbox"/> Other (please specify): _____                           |
| <input type="checkbox"/> GERD  |  |

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**

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