FirstCarolinaCare
INSURANCE COMPANY

Proton Pump Inhibitors (PPIs)

Medication Request Form (MRF)
FAX TO: (858) 790-7100
c/o MedImpact Healthcare Systems, Inc.

Attn: Prior Authorization Department
10680 Treena Street, Suite 500, San Diego, CA 92131 - Phone: 1-800-788-2949

Instructions:
This form is to be used by participating physicians and providers to obtain coverage for proton pump inhibitors (PPIs). Please complete this form and fax to Med**Impact** Healthcare Systems, Inc. at (858) 790-7100 or please call (800) 788-2949 with this information. If you have any questions regarding this process, please contact Med**Impact**'s Customer Service at (800) 788-2949.

☐ **REQUEST FOR EXPEDITED (URGENT) REVIEW**: BY CHECKING THIS BOX, I CERTIFY THAT APPLYING THE STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

***** ONLY COMPLETED FORMS CAN BE PROCESSED *****

Member/Provider Information:

Member's Name:	**Provider's Name:**
Member's ID #:	**Provider's Specialty:**
Member's DOB (mm-dd-yy):	**ID#/DEA #:**
Pharmacy used by Member:	**Provider's Telephone Number/Contact Name:**
Pharmacy (Area Code) Telephone Number:	**Provider's (Area Code) Fax Number:**

Clinical Information:

Requested Drug: (Note: Omeprazole and pantoprazole do not require authorization)

☐ Aciphex
☐ Dexilant
☐ Nexium
☐ Prevacid/lansoprazole
☐ Zegerid

Dose and Quantity Requested:

Date Requested:	**Length of Treatment** (please be specific):

Documentation of Medical Necessity:

1. Is the member pregnant? ☐ Yes ☐ No
2. Is the member currently taking Plavix (clopidogrel)? ☐ Yes ☐ No
3. Has the patient tried and failed or is intolerant to **40mg per day** of omeprazole? ☐ Yes ☐ No
4. Has the patient tried and failed or is intolerant to Protonix or pantoprazole? ☐ Yes ☐ No
5. Other Pertinent History (relative or pertaining to this request):

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Signature:

I certify that the information provided is accurate and complete to the best of my knowledge. I understand that FCC may request medical records for this patient at any time in order to verify this information. I further understand that any falsification, omission, or concealment of material fact may be grounds for sanctions.

___________________________________ *Signature (Required)*

DO NOT WRITE IN SHADED AREAS FOR INTERNAL USE ONLY
Contacted:
Provider:
Pharmacy:
Patient:

DO NOT WRITE IN SHADED AREAS FOR INTERNAL USE ONLY
Approved:
Denied:
Returned:
PA #