



**CIGNA**

**Pharmacy Services**

Phone: (800)244-6224

Fax: (800)390-9745

# CIGNA HealthCare Prior Authorization Form

## - Proton Pump Inhibitor Medications -

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

PROVIDER INFORMATION			PATIENT INFORMATION		
* Provider Name:			**Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed**		
Specialty:	* DEA or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* CIGNA ID:		
Office Fax:			* Date Of Birth:		
* Is your fax machine kept in a secure location? Yes <input type="checkbox"/> No <input type="checkbox"/>			* Patient Street Address:		
* May we fax our response to your office? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		
<b>Medication requested:</b> (please note, Omeprazole 20mg, Prevacid <sup>®</sup> and Protonix <sup>®</sup> are CIGNA's preferred PPI's) <input type="checkbox"/> omeprazole <input type="checkbox"/> Prevacid <sup>®</sup> <input type="checkbox"/> Protonix <sup>®</sup> <input type="checkbox"/> Aciphex <sup>®</sup> <input type="checkbox"/> Prilosec <sup>®</sup> <input type="checkbox"/> Nexium <sup>®</sup> <input type="checkbox"/> Zegerid <sup>®</sup> <input type="checkbox"/> Kapidex <sup>®</sup>					
Strength:			Dose:		
<b>Diagnosis related to use:</b> (please check all that apply) <input type="checkbox"/> GERD (Gastro-Esophageal Reflux Disease) <input type="checkbox"/> Ulcer <input type="checkbox"/> Erosive Esophagitis <input type="checkbox"/> Esophageal Stricture <input type="checkbox"/> LPR (Laryngopharyngeal Reflux) <input type="checkbox"/> Asthma <input type="checkbox"/> Barrett's Esophagus <input type="checkbox"/> Other (please specify):					
<b>Other Proton Pump Inhibitor's (PPI's) tried:</b> Has the patient failed treatment with any of the following Proton Pump Inhibitors? (please check all that apply) <input type="checkbox"/> omeprazole (generic PRILLOSEC <sup>®</sup> , PRILLOSEC OTC <sup>®</sup> ) <input type="checkbox"/> lansoprazole (generic PREVACID <sup>®</sup> ) <input type="checkbox"/> pantoprazole sodium (generic PROTONIX <sup>®</sup> ) <input type="checkbox"/> PROTONIX <sup>®</sup>					
<b>If Diagnosis is GERD:</b> Has the patient failed treatment with one of the following agents at or above the given dose for at least 30 days? <input type="checkbox"/> Ranitidine (ZANTAC <sup>®</sup> ) 150mg BID <input type="checkbox"/> Nizatidine (AXID <sup>®</sup> ) 150mg BID <input type="checkbox"/> Cimetidine (TAGAMET <sup>®</sup> ) 800mg BID <input type="checkbox"/> Famotidine (PEPCID <sup>®</sup> ) 20mg BID <input type="checkbox"/> Metoclopramide (REGLAN <sup>®</sup> ) any dosage					
<b>If Diagnosis is Ulcer:</b> <input type="checkbox"/> The patient tested negative (-) for H. pylori.   Please indicate the date tested: <input type="checkbox"/> The patient tested positive (+) for H. pylori and has been treated according to CDC guidelines. Please indicate the date of treatment: <input type="checkbox"/> This patient has been treated for H. pylori, but has a recurrent ulcer. Please indicate the date of treatment:					
<b>If Diagnosis is Erosive Esophagitis:</b> What is the grade? <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV   Is there stricture present? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Please fax completed form to (800)390-9745. Phone requests may be submitted by calling (800)244-6224.</b> Our standard response time for prescription drug coverage requests is 2-4 business days. If your request is urgent, it is important that you call Pharmacy Services to expedite the request. View our formulary on line at <a href="http://www.cigna.com">http://www.cigna.com</a> .					

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