



**Pharmacy Prior Authorization Form PPI Medications – HMO/POS/PPO
Fax Completed Form to (818) 676-8086**

PA forms and guidelines are available on the provider portal of www.healthnet.com

If The Fax No. Provided is Not A Dedicated Machine To You or Your Staff, Please Check This Box

Patient Name	Date of Birth
Patient's ID Number	Patient's Phone Number
Physician's Name and Specialty	Are you the patient's primary care physician? <input type="checkbox"/> YES <input type="checkbox"/> NO
Physician's Phone Number ()	Physician's Fax Number ()
Pharmacy Phone Number ()	Pharmacy Fax Number ()
Diagnosis:	ICD-9 code:

Medication	Strength	Directions	Qty/mth	Duration
<input type="checkbox"/> Aciphex	20 mg			
<input type="checkbox"/>				

Medications Tried and Failed:				
Date of Trial	Medication and Strength	Directions	Duration	Outcome
	Aciphex 20 mg			
	Protonix* <input type="checkbox"/> 20 mg <input type="checkbox"/> 40 mg			
	Prevacid SoluTabs* ^ψ <input type="checkbox"/> 15 mg <input type="checkbox"/> 30 mg Prevacid capsules* ^f <input type="checkbox"/> 15 mg <input type="checkbox"/> 30 mg			
	Nexium* ^f <input type="checkbox"/> 20 mg <input type="checkbox"/> 40 mg			
	Prilosec* ^{f,♦} <input type="checkbox"/> 10 mg <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg			

*Not on the Health Net Recommended Drug List

^ψHealth Net coverage criteria requires documented adequate trial of formulary Aciphex as well as Protonix (available at Tier 3 for members with 3-tier plans or requires prior authorization for 2-tier plans)

^fHealth Net coverage criteria requires documented adequate trial of formulary Aciphex, a trial of Protonix (available at Tier 3 for members with 3-tier plans or requires prior authorization for 2-tier plans) and Prevacid SoluTabs (require prior authorization).

[♦]Prilosec OTC (equivalent to omeprazole 20 mg) is not covered.

<p>Please answer the following questions:</p> <p>1. Is the patient on concurrent NSAIDS, prednisone, or similar products? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Additional clinical reason(s): _____ _____ _____</p>

I certify that the above information is correct to the best of my knowledge.

Physician's Signature _____ Date _____

This message, together with any attachments, is intended only for the use of the individual or entity to which it is addressed and may contain information that is confidential and prohibited from disclosure. If you are not the intended recipient, you are hereby notified that any dissemination, or copying of this message, or any attachment, is strictly prohibited. If you have received this message in error, please notify the original sender immediately by telephone or by return E-mail and delete this message along with any attachments, from your computer. Thank you.