

**PROTON PUMP INHIBITOR (PPI)
STEP THERAPY WITH QUANTITY LIMIT
PHYSICIAN FAX FORM**



ONLY the prescriber may complete this form.

The following documentation is **REQUIRED** for authorization. Incomplete forms will be returned for additional information. For formulary information, please visit the PrimeWest Health web site at www.primewest.org.

Today's Date: _____

PATIENT INFORMATION

Patient Name (First):	Last:	M:	Patient Telephone Number:	DOB (mm/dd/yy):
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HEALTH PLAN INFORMATION

Member's Insurance ID Number:	Member's Insurance Group Number:
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PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<p>1. Does the patient have a diagnosis of a hypersecretory disease?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Does the patient require more than once daily dosing for control of symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Can the patient's dose be accomplished with a lesser quantity of tablets at a higher strength (e.g. one 20 mg instead of two 10 mg tablets)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. (Please specify if the patient has tried brand-name products, generic products or over-the-counter products.) _____ _____</p> <p>5. Please list all reasons for selecting the requested medication over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.) _____ _____</p>	

Please fax or mail this form to:
 PrimeWest Health System
 Clinical Review Department
 1020 Discovery Road, No. 100
 Eagan, Minnesota 55121

TOLL FREE

Fax: 877.480.8130 Phone: 800.711.9866

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