CAREFIRST DC RISK VF
Zegerid

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2038 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Zegerid.

Patient Information

Patient Name:

Patient Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Patient ID:

Patient Group No:

Patient DOB: ☐☐ / ☐☐ / ☐☐☐☐

Prescribing Physician

Physician Name:

Physician Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Address:

City, State, Zip:

Drug Name (select from list of drugs shown)

Omeprazole-Sod Bicarbonate

Zegerid (omeprazole-sodium bicarbonate)

Zegerid Capsules (omeprazole-sodium bicarbonate)

Zegerid Oral Pkt (omeprazole-sodium bicarbonate)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

_____

Please check the appropriate answer for each applicable question.

1. Has the patient experienced an inadequate treatment response to THREE generic proton pump inhibitors? **Y** ☐ **N** ☐
2. Has the patient experienced an intolerance to THREE generic proton pump inhibitors? **Y** ☐ **N** ☐
3. Does the patient have a contraindication that would prohibit a trial of THREE generic proton pump inhibitors? **Y** ☐ **N** ☐
4. Is the requested drug being prescribed for any of the following: A) Gastroesophageal reflux disease (GERD), B) Duodenal ulcer, C) Gastric ulcer, D) Short-term treatment of erosive esophagitis? **Y** ☐ **N** ☐
5. Does the patient require more than the plan allowance of 30 capsules or 30 packets for oral suspension per month? **Y** ☐ **N** ☐
6. Is the requested drug being prescribed for the maintenance of healing of erosive esophagitis? **Y** ☐ **N** ☐
7. Does the patient require more than the plan allowance of 30 capsules or 30 packets for oral suspension per month? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.