



**PROTON PUMP INHIBITOR PRIOR AUTHORIZATION**  
 ND DEPARTMENT OF HUMAN SERVICES  
 MEDICAL SERVICES DIVISION  
 SFN 850 (Rev. 2/2004)

**Send to:** Medical Services Division  
 ND Department of Human Services  
 600 E Boulevard Ave, Dept. 325  
 Bismarck, ND 58505  
**Fax: (701) 328-1544**

North Dakota Medicaid requires that patients receiving proton pump inhibitors must use **Prilosec OTC\*** as first line.

- \*Note:**
- **Prilosec OTC may be prescribed WITHOUT prior authorization. Prilosec OTC is covered by Medicaid when prescribed by a physician.**
  - **Prior Authorization is NOT required for patients < 13 years of age.**
  - **Patients must use Prilosec OTC for a minimum of 14 days for the trial to be considered a failure. Patient preference does not constitute a failure.**
  - **Net cost to Medicaid: Prilosec OTC <<< Protonix < Aciphex < Prevacid < omeprazole << Nexium < Prilosec**

**Part I: TO BE COMPLETED BY PHYSICIAN - COMPLETE PART I AND FAX TO PATIENT'S PHARMACY**

Recipient Name		Recipient Date of Birth		Recipient Medicaid ID Number	
Physician Name		Physician Medicaid Provider Number		Telephone Number	Fax Number
Address		City		State	Zip Code
<b>Requested Drug:</b>		<b>Requested Dosage (must be completed)</b>			
Protonix      Aciphex      Nexium		<b>Diagnosis for this request</b>			
Prevacid      Prilosec					

**Qualifications for coverage:**

Failed omeprazole OTC	Start Date	End Date	Dose	Frequency
Adverse Reaction to omeprazole OTC (attach FDA Medwatch form) or Contraindicated (provide description below)				
Pregnancy - Due Date:				
Inability to take or tolerate oral tablets (must check a box below)				
<input type="checkbox"/> Tube Fed <input type="checkbox"/> Requires soft food or liquid administration <input type="checkbox"/> Other (provide description)				
Physician Signature			Date	

**Part II: TO BE COMPLETED BY PHARMACY - COMPLETE PART II AND FAX OR MAIL TO MEDICAID**

Pharmacy Name		ND Medicaid Provider Number	
Telephone Number	Fax Number	Drug	NDC #

**Part III: FOR STATE USE ONLY**

Date Received      /      /	CSP MD      Y / N	Daily Units	Req	CLM
	CSP Pharmacy Y / N	Bypass Units Y / N	App	Limit
Approved - Effective dates of PA	From:      /      /	To:      /      /	Approved By	
Denied (Reasons)				