



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations. Visit [go.covermymeds.com/OptumRx](http://go.covermymeds.com/OptumRx) to begin using this free service. Please note: All information below is required to process this request. Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

## Lansoprazole Delayed-Release Orally Disintegrating Tablet Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

<b>Member Information</b> (required)			<b>Provider Information</b> (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
<b>Medication Information</b> (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
<b>Clinical Information</b> (required)					
<p><b>Continuation of therapy:</b> Is this a continuation of prior therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" to the above question, please submit documentation (e.g., medical records, chart notes, pharmacy claims) or provide the dates, duration, and previous regimen used below: <b>(REQUIRED)</b></p> <p>_____</p> <p>_____</p>					
<p><b>Select the diagnosis below:</b></p> <p><input type="checkbox"/> Duodenal ulcer</p> <p><input type="checkbox"/> Erosive esophagitis</p> <p><input type="checkbox"/> Gastric ulcer</p> <p><input type="checkbox"/> Gastroesophageal reflux disease (GERD)</p> <p><input type="checkbox"/> Helicobacter pylori gastrointestinal tract infection</p> <p><input type="checkbox"/> Non-steroidal anti-inflammatory drug (NSAID)-associated gastric ulcer</p> <p><input type="checkbox"/> Pathological hypersecretory conditions including Zollinger-Ellison Syndrome</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>					
<p><b>Clinical information:</b> Is there documentation why the patient is unable to use capsules? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" to the above question, please specify: _____</p> <p>_____</p>					
<p>Are there contraindications or absolute drug interactions with existing therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

\_\_\_\_\_

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**Please note:** This request may be denied unless all required information is received.  
For urgent or expedited requests please call 1-800-711-4555.  
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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