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Visit 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

Zegerid® (omeprazole-sodium bicarbonate) Prior Authorization Request Form

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

Member Information (required)			Provider Information (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:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Duodenal ulcer <input type="checkbox"/> Erosive esophagitis <input type="checkbox"/> Gastric ulcer <input type="checkbox"/> Gastroesophageal reflux disease (GERD) <input type="checkbox"/> Risk reduction of upper gastrointestinal (GI) hemorrhage in critically ill patients [Zegerid (omeprazole-sodium bicarbonate) oral suspension only] <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	

Select the medications the patient has a failure, contraindication, or intolerance to:	
<input type="checkbox"/> Aciphex <input type="checkbox"/> Dexilant <input type="checkbox"/> Esomeprazole magnesium <input type="checkbox"/> Esomeprazole sodium <input type="checkbox"/> Esomeprazole strontium <input type="checkbox"/> Lansoprazole capsule <input type="checkbox"/> Lansoprazole orally disintegrating tablet (ODT) <input type="checkbox"/> Nexium capsule <input type="checkbox"/> Nexium granule	<input type="checkbox"/> Omeprazole capsule <input type="checkbox"/> Omeprazole-sodium bicarbonate <input type="checkbox"/> Pantoprazole <input type="checkbox"/> Prevacid <input type="checkbox"/> Prevacid Solutab <input type="checkbox"/> Prilosec granule <input type="checkbox"/> Protonix <input type="checkbox"/> Rabeprazole

Quantity limit requests: What is the quantity requested per DAY? _____ What is the reason for exceeding the plan limitations? <input type="checkbox"/> Titration or loading-dose purposes <input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime) <input type="checkbox"/> Requested strength/dose is not commercially available <input type="checkbox"/> There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. Please specify: _____ <input type="checkbox"/> Other: _____

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

Please note: This request may be denied unless all required information is received.
 If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
 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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 Office use only: Zegerid-OmeprazoleSodiumBicarbonate_CMS_2019Jan-W