

Patient's Name:	Today's Date:
Patient's DOB:	Office Phone Number:
Patient's Member ID:	Office Fax Number:
Office Contact should we have questions:	Physician Name (print):
Office Contact Phone Number/Extension:	<b>Physician Signature:</b>

**PROTON PUMP INHIBITORS**

Available without step therapy: Omeprazole capsules, pantoprazole. Some Commercial SummaCare benefits cover OTC PPIs at the Tier 1 copay level when the prescription indicates OTC. OTC PPIs are not covered under SummaCare Medicare Part D plans.

**Drug Requested:**

- |                                  |                                   |                                       |                                   |
|----------------------------------|-----------------------------------|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Nexium  | <input type="checkbox"/> Aciphex  | <input type="checkbox"/> lansoprazole | <input type="checkbox"/> Protonix |
| <input type="checkbox"/> Kapidex | <input type="checkbox"/> Prevacid | <input type="checkbox"/> Prilosec     | <input type="checkbox"/> Zegerid  |

**Dose Requested:** \_\_\_\_\_mg **Frequency of dosing:** \_\_\_\_\_ **Other information:** \_\_\_\_\_

**Diagnosis (select all that apply):**

- |   |  |   |                                   |  |
|---|--|---|-----------------------------------|--|
| <input type="checkbox"/> GERD                     | <input type="checkbox"/> H. pylori           | <input type="checkbox"/> Laryngopharyngeal reflux | <input type="checkbox"/> GI bleed | <input type="checkbox"/> Ulcer (specify type): _____ |
| <input type="checkbox"/> Hypersecretory condition | <input type="checkbox"/> Barrett's esophagus | <input type="checkbox"/> Other: _____             |                                   |  |

**List all previous therapies (including OTCs) and include dates of use:**

**NON-SEDATING ANTIHISTAMINES**

Available without step therapy: OTC NSA's (covered by SummaCare when the prescription indicates OTC). Patients must try and fail 2 OTC agents prior to coverage

**Drug Requested:**

- |                                   |                                     |   |
|-----------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Clarinex | <input type="checkbox"/> Clarinex D | <input type="checkbox"/> levocetirizine (generic for Xyzal) |
|-----------------------------------|-------------------------------------|---|

**Dose Requested:** \_\_\_\_\_mg **Frequency of dosing:** \_\_\_\_\_ **Other information:** \_\_\_\_\_

**Diagnosis (select all that apply):**

- |  |   |                                 |                                     |                                       |
|--|---|---------------------------------|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Allergic rhinitis | <input type="checkbox"/> Chronic idiopathic urticaria | <input type="checkbox"/> Asthma | <input type="checkbox"/> Angioedema | <input type="checkbox"/> Other: _____ |
|--|---|---------------------------------|-------------------------------------|---------------------------------------|

**List all previous therapies (including OTCs) and include dates of use:**

**TRIPTANS**

Available without step therapy: Generic sumatriptan, generic naratriptan, Maxalt, Maxalt MLT, Relpax

**Drug Requested:**

- |                                  |  |   |   |
|----------------------------------|--|---|---|
| <input type="checkbox"/> Axert   | <input type="checkbox"/> Alsuma (requires documented failure with sumatriptan injection) | <input type="checkbox"/> Sumavel (requires documented failure with sumatriptan injection) | <input type="checkbox"/> Treximet (requires documentation of failure with both generic sumatriptan and prescription only forms of Naproxen) |
| <input type="checkbox"/> Frova   |  |   |   |
| <input type="checkbox"/> Amerge  |  |   |   |
| <input type="checkbox"/> Imitrex |  |   |   |
| <input type="checkbox"/> Zomig   |  |   |   |

**Dose Requested:** \_\_\_\_\_mg **Frequency of dosing:** \_\_\_\_\_ **Other information:** \_\_\_\_\_

**Diagnosis (select all that apply):**

- |                                   |   |                                       |
|-----------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Cluster headache | <input type="checkbox"/> Other: _____ |
|-----------------------------------|---|---------------------------------------|

**List all previous therapies and include dates of use:**

**ARBs, ARB Combinations, Renin Inhibitors**

Available without step therapy: Any generic ACE Inhibitor and ACE Inhibitor Combination, losartan, losartan-HCT

**Drug Requested:**

- |   |   |  |   |                                    |
|---|---|--|---|------------------------------------|
| <input type="checkbox"/> Benicar +/-HCT | <input type="checkbox"/> Atacand +/- HCT  | <input type="checkbox"/> Azor            | <input type="checkbox"/> Valtorna         | <input type="checkbox"/> Tribenzor |
| <input type="checkbox"/> Diovan +/- HCT | <input type="checkbox"/> Micardis +/- HCT | <input type="checkbox"/> Exforge +/- HCT | <input type="checkbox"/> Tekturna +/- HCT | <input type="checkbox"/> Edarbi    |
| <input type="checkbox"/> Avapro/Avalide | <input type="checkbox"/> Teveten +/- HCT  | <input type="checkbox"/> Twynsta         | <input type="checkbox"/> Tekamlo          | <input type="checkbox"/> Amturnide |

**Dose Requested:** \_\_\_\_\_mg **Frequency of dosing:** \_\_\_\_\_ **Other information:** \_\_\_\_\_

**Diagnosis (select all that apply):**

- |   |  |   |                                  |
|---|--|---|----------------------------------|
| <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Proteinuria   | <input type="checkbox"/> Stroke prophylaxis | <input type="checkbox"/> Post MI |
| <input type="checkbox"/> Diabetic nephropathy | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> MI prophylaxis     |                                  |

**List all previous therapies and include dates of use:**