



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
 P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Proton Pump Inhibitor Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at www.mass.gov/druglist.

Member information

Last name _____ First name _____ MI _____
 MassHealth member ID # _____ Date of birth _____
 Gender (Check one.) F M Member's place of residence home nursing facility

Medication information

Medication requested

- | | |
|---|---|
| <input type="checkbox"/> Aciphex Sprinkle (rabeprazole delayed release capsule) | <input type="checkbox"/> omeprazole 10 mg > 30 units/month |
| <input type="checkbox"/> Dexilant (dexlansoprazole) >30 units/month | <input type="checkbox"/> omeprazole 20 mg > 120 units/month |
| <input type="checkbox"/> esomeprazole magnesium capsule >30 units/month | <input type="checkbox"/> omeprazole 40 mg > 60 units/month |
| <input type="checkbox"/> esomeprazole magnesium suspension | <input type="checkbox"/> omeprazole/sodium bicarbonate |
| <input type="checkbox"/> esomeprazole sodium IV | <input type="checkbox"/> pantoprazole tablet > 120 units/month |
| <input type="checkbox"/> esomeprazole strontium | <input type="checkbox"/> Prilosec (omeprazole suspension) |
| <input type="checkbox"/> lansoprazole capsule >30 units/month | <input type="checkbox"/> Protonix (pantoprazole 40 mg suspension) |
| <input type="checkbox"/> lansoprazole orally disintegrating tablet (≥ 2 years of age) | <input type="checkbox"/> rabeprazole delayed-release tablet >30 units/month |

Dose and frequency of requested agent _____

Intended duration of therapy _____

Indication (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> GERD | (GERD continued) |
| <input type="checkbox"/> Moderate-severe erosive esophagitis | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Uncomplicated nonerosive esophagitis | _____ |
| <input type="checkbox"/> Barrett's esophagus | _____ |
| <input type="checkbox"/> GERD in child with one of the following conditions | <input type="checkbox"/> Condition associated with extraesophageal symptoms secondary to gastric reflux |
| <input type="checkbox"/> Severe chronic respiratory disease (specify) _____ | <input type="checkbox"/> Noncardiac chest pain |
| _____ | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Neurologic disability (specify) _____ | <input type="checkbox"/> Idiopathic hoarseness |
| _____ | <input type="checkbox"/> Chronic laryngitis |
| | <input type="checkbox"/> Other (explain) _____ |

Duodenal ulcer

Helicobacter pylori

Drug-induced

Treatment. List causative agent(s).

Prevention. List risk factor(s).

Other cause (specify)

Gastric ulcer

Positive

Negative

Pathological hypersecretory syndromes

Zollinger-Ellison syndrome

MEN Type I

Other

Other (explain)

Diagnostic studies performed (include dates of studies). Describe any diagnostic studies performed, including dates of studies. _____

Section I. Please complete for requests for Aciphex Sprinkle, esomeprazole magnesium suspension or strontium, lansoprazole orally disintegrating tablet, omeprazole/sodium bicarbonate, Prilosec suspension, and Protonix 40 mg suspension.

1. Has the member tried omeprazole?

Yes. Provide the following information.
 Dates/duration of use _____ Dose and frequency _____
 Why was it discontinued? (Check one or all that apply.) Adverse reaction Inadequate response Other
 Details of adverse reaction, inadequate response, or other _____

No. Explain why not. _____
2. Has the member tried pantoprazole?

Yes. Provide the following information.
 Dates/duration of use _____ Dose and frequency _____
 Why was it discontinued? (Check one or all that apply.) Adverse reaction Inadequate response Other
 Details of adverse reaction, inadequate response, or other _____

No. Explain why not. _____
3. Has the member tried lansoprazole capsules, rabeprazole tablet or esomeprazole magnesium capsule?

Yes. Provide the following information.
 Drug _____ Dates/duration of use _____ Dose and frequency _____
 Why was it discontinued? (Check one or all that apply.) Adverse reaction Inadequate response Other
 Details of adverse reaction, inadequate response, or other _____

No. Explain why not. _____
4. For omeprazole/sodium bicarbonate suspension, provide medical necessity for the requested agent over all available proton pump inhibitor dissolving, sprinkled, and suspension/packet formulations.

Section II. Please complete for requests for omeprazole 20 mg at quantities > 120 units/month, omeprazole 40 mg capsules and pantoprazole tablets > 120 units/ month, and any other oral proton pump inhibitor at quantities > 30 units/month.

Please describe the medical necessity for use above the established quantity limits.

Section III. Please complete for requests for esomeprazole sodium IV.

1. Please describe the medical necessity for intravenous route of administration. _____

2. Has the member tried pantoprazole IV?

Yes. Dose and frequency _____ Dates of use _____ Outcome _____

No. Please explain why not. _____

Section IV. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

Prescriber information

Last Name* _____ First Name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

* Required

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____