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

Print Clear

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

☐ Aciphex Sprinkle (rabeprazole delayed release capsule)
☐ esomeprazole magnesium capsule > 1 unit/day
☐ esomeprazole magnesium 2.5 mg, 5 mg suspension
☐ esomeprazole sodium IV
☐ lansoprazole capsule > 1 unit/day
☐ lansoprazole orally disintegrating tablet (≥ 2 years of age)
☐ omeprazole 10 mg > 1 unit/day
☐ omeprazole 20 mg > 4 units/day
☐ omeprazole 40 mg > 2 units/day
☐ omeprazole/sodium bicarbonate suspension
☐ pantoprazole tablet > 4 units/day
☐ Prilosec (omeprazole suspension)
☐ pantoprazole 40 mg suspension
☐ rabeprazole delayed-release tablet > 1 unit/day

Dose and frequency of requested agent _____

Intended duration of therapy _____

Indication (Check all that apply)

☐ **GERD**
- ☐ Moderate-severe erosive esophagitis
- ☐ Uncomplicated nonerosive esophagitis
- ☐ Barrett's esophagus
- ☐ GERD in child with one of the following conditions
  - ☐ Severe chronic respiratory disease (specify)
    _____
    _____
  - ☐ Neurologic disability (specify)
    _____

(GERD continued)
- ☐ Other (specify)
  _____
  _____

☐ **Condition associated with extraesophageal symptoms secondary to gastric reflux**
- ☐ Noncardiac chest pain
- ☐ Asthma
- ☐ Idiopathic hoarseness
- ☐ Chronic laryngitis
- ☐ 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 2.5 mg and 5 mg suspension, lansoprazole orally disintegrating tablet, omeprazole/sodium bicarbonate suspension, Prilosec suspension, and pantoprazole 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.

   _____
   _____

over

Section II. Please complete for requests for omeprazole 20 mg capsules and pantoprazole tablets at quantities > 4 units/day, omeprazole 40 mg capsules > 2 units/day, and any other oral proton pump inhibitor at quantities > 1 unit/day.

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 _____