



# Prior Authorization Request Administrative Information

## Member information

Last name  First name  MI

Member ID  Date of birth

Sex assigned at birth  Female  Male  "X" or Intersex

Current gender  Female  Male  Transgender male  Transgender female  Other

Place of residence  Home  Nursing facility  Other

Race  Ethnicity

Preferred spoken language  Preferred written language

MassHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, creed, sexual orientation, or sex (including gender identity and gender stereotyping).

## Plan contact information

Please indicate the member's MassHealth Plan and fax or submit this completed and signed form according to the Plan's contact information below.

<b>MassHealth Fee-For-Service (FFS) Plan, Primary Care Clinician (PCC) Plan, Primary Care Accountable Care Organization (PCACO) Plan, Children's Medical Security Plan, and Health Safety Net Plan</b>	
<input type="checkbox"/>	<b>MassHealth Drug Utilization Review Program</b> Pharmacy: Fax: (877) 208-7428 - Tel: (800) 745-7318
<b>MassHealth Managed Care Organization (MCO) and Accountable Care Partnership Plans (ACPP)</b>	
<input type="checkbox"/>	<b>Fallon Health</b> Online Prior Authorization: <a href="http://go.covermymeds.com/OptumRx">go.covermymeds.com/OptumRx</a> Online Prior Authorization: <a href="http://providerportal.surescripts.net/ProviderPortal/optum">providerportal.surescripts.net/ProviderPortal/optum</a> Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033
<input type="checkbox"/>	<b>Health New England</b> Online Prior Authorization: <a href="http://go.covermymeds.com/OptumRx">go.covermymeds.com/OptumRx</a> Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545
<input type="checkbox"/>	<b>Mass General Brigham Health Plan</b> Online Prior Authorization (Non-Specialty Drugs): <a href="http://go.covermymeds.com/OptumRx">go.covermymeds.com/OptumRx</a> Online Prior Authorization (Specialty/Medical Drugs): <a href="http://provider.massgeneralbrighamhealthplan.org">provider.massgeneralbrighamhealthplan.org</a> Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555
<input type="checkbox"/>	<b>Tufts Health Plan</b> Online Prior Authorization: <a href="http://point32health.promptpa.com">point32health.promptpa.com</a> Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985
<input type="checkbox"/>	<b>WellSense Health Plan</b> Online Prior Authorization: <a href="http://wellsense.org/providers/ma/pharmacy/prior-authorizations">wellsense.org/providers/ma/pharmacy/prior-authorizations</a> Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822

# 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](http://www.mass.gov/druglist).

## Medication information

### Medication requested

- |  |  |
|--|--|
| <input type="checkbox"/> Aciphex Sprinkle (rabeprazole delayed release capsule)                                | <input type="checkbox"/> Konvomep (omeprazole/sodium bicarbonate suspension) |
| <input type="checkbox"/> dexlansoprazole   | <input type="checkbox"/> lansoprazole capsule > 1 unit/day                   |
| <input type="checkbox"/> esomeprazole magnesium capsule > 1 unit/day   | <input type="checkbox"/> omeprazole 10 mg > 1 unit/day                       |
| <input type="checkbox"/> esomeprazole magnesium 20 mg, 40 mg suspension  | <input type="checkbox"/> omeprazole 20 mg > 4 units/day                      |
| <input type="checkbox"/> esomeprazole magnesium 2.5 mg, 5 mg, 10 mg suspension $\geq$ 2 years and > 1 unit/day | <input type="checkbox"/> omeprazole 40 mg > 2 units/day                      |
| <input type="checkbox"/> esomeprazole sodium IV  | <input type="checkbox"/> pantoprazole tablet > 4 units/day                   |
| <input type="checkbox"/> First-Omeprazole (omeprazole suspension compounding kit)                              | <input type="checkbox"/> Prilosec (omeprazole suspension)                    |
|  | <input type="checkbox"/> rabeprazole delayed-release tablet > 1 unit/day     |

Dose and frequency of requested agent

Intended duration of therapy

Indication (Check all that apply or include ICD-10 code, if applicable)

### 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)

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.

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**Section I. Please complete for requests for Aciphex Sprinkle, dexlansoprazole, esomeprazole magnesium 2.5 mg and 5 mg suspension, esomeprazole 20 mg, 40 mg suspension, and Prilosec suspension.**

Has the member had a trial with esomeprazole magnesium capsule, lansoprazole, omeprazole, pantoprazole, or rabeprazole tablet?

Yes. Please list the specific drug name, dates/duration of use, and outcomes below.

Drug name, dose and frequency

Dates/duration of use

Did the member experience any of the following?  Adverse reaction  Inadequate response  Other

Briefly describe details of adverse reaction, inadequate response, or other.

Drug name, dose and frequency

Dates/duration of use

Did the member experience any of the following?  Adverse reaction  Inadequate response  Other

Briefly describe details of adverse reaction, inadequate response, or other.

No. Please describe clinical rationale why these trials are not appropriate for this member.

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**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 medical necessity for use above the established quantity limits. Attach medical records documenting inadequate response to once daily dosing of the requested agent, with dates, as appropriate.

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**Section III. Please complete for requests for esomeprazole sodium IV and First-Omeprazole.**

1. Please describe medical necessity for use of the requested formulation.

2. For esomeprazole sodium IV, has the member had a trial with pantoprazole IV?

Yes. Please list dates/duration of use and outcomes below.

Dates/duration of use

Did the member experience any of the following?  Adverse reaction  Inadequate response  Other

No. Please describe clinical rationale why pantoprazole IV is not appropriate for this member.

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**Section IV. Please complete for requests for Konvomep.**

1. Has the member had a trial with two of the following: esomeprazole suspension, lansoprazole orally disintegrating tablet, omeprazole capsule, or pantoprazole suspension?

Yes. Please list the drug name, dose, frequency, dates/duration of use, and outcomes below.

Drug name, dose, and frequency  Dates/duration of use

Did the member experience any of the following?  Adverse reaction  Inadequate response  Other

Briefly describe details of adverse reaction, inadequate response, or other.

Drug name, dose, and frequency  Dates/duration of use

Did the member experience any of the following?  Adverse reaction  Inadequate response

Briefly describe details of adverse reaction, inadequate response, or other.

No. Please describe clinical rationale why these trials are not appropriate for this member.

2. Has the member had a trial with omeprazole/sodium bicarbonate powder for oral suspension [Zegerid]?

Yes. Please list the dose, frequency, dates/duration of use, and outcomes below.

Drug dose and frequency  Dates/duration of use

Did the member experience any of the following?  Adverse reaction  Inadequate response  Other

Briefly describe details of adverse reaction, inadequate response, or other.

No. Please describe clinical rationale why this trial is not appropriate for this member.

3. Please describe medical necessity for use of the requested formulation.

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**Section V. Please complete for requests for esomeprazole 2.5 mg, 5 mg, 10 mg suspension  $\geq 2$  years of age and  $> 1$  unit/day.**

Please attach medical records documenting inadequate response to once daily dosing of the requested agent, with dates, as appropriate.

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**Section VI. Please complete and provide documentation for exceptions to step therapy.**

1. Is the alternative drug required under the step therapy protocol contraindicated, or will likely cause an adverse reaction in, or physical or mental harm to, the member?  Yes  No

If yes, briefly describe details of contraindication, adverse reaction, or harm.

2. Is the alternative drug required under the step therapy protocol expected to be ineffective based on the known clinical characteristics of the member and the known characteristics of the alternative drug regimen?

Yes  No

If yes, briefly describe details of known clinical characteristics of member and alternative drug regimen.

  

3. Has the member previously tried the alternative drug required under the step therapy protocol, or another alternative drug in the same pharmacologic class or with the same mechanism of action, and such alternative drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?

Yes  No

If yes, please provide details for the previous trial.

Drug name

Dates/duration of use

Did the member experience any of the following?  Adverse reaction  Inadequate response

Briefly describe details of adverse reaction or inadequate response.

  

4. Is the member stable on the requested prescription drug prescribed by the healthcare provider, and switching drugs will likely cause an adverse reaction in, or physical or mental harm to, the member?

Yes. Please provide details.

No

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**Please continue to next page and complete Prescriber and Provider Information section.**

# Prior Authorization Request Prescriber and Provider Information

## Prescriber information

Last name*	<input type="text"/>	First name*	<input type="text"/>	MI	<input type="text"/>
NPI*	<input type="text"/>	Individual MH Provider ID	<input type="text"/>		
DEA No.	<input type="text"/>	Office Contact Name	<input type="text"/>		
Address	<input type="text"/>	City	<input type="text"/>	State	<input type="text"/>
		Zip	<input type="text"/>		
E-mail address	<input type="text"/>				
Telephone No.*	<input type="text"/>				
Fax No.* (Please provide fax number for PA response notification.)	<input type="text"/>				

\* Required

## Please also complete for professionally administered medications, if applicable.

Start date	<input type="text"/>	End date	<input type="text"/>		
Servicing prescriber/facility name	<input type="text"/>	<input type="checkbox"/>	Same as prescribing provider		
Servicing provider/facility address	<input type="text"/>				
Servicing provider NPI/tax ID No.	<input type="text"/>				
Name of billing provider	<input type="text"/>				
Billing provider NPI No.	<input type="text"/>				
Is this a request for recertification?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
CPT code	<input type="text"/>	No. of visits	<input type="text"/>	J code	<input type="text"/>
		No. of units	<input type="text"/>		

## Provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am either the prescribing provider or duly authorized to act on behalf of the provider identified in the Prescriber information section of this form. Any attached statement on 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.

### Signature of provider or individual duly authorized to act on behalf of the provider:

Printed legal name and title of signatory above

<input type="text"/>	Date	<input type="text"/>
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(The form can either be signed by hand and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.)