pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

PROTON PUMP INHIBITORS PRIOR AUTHORIZATION FORM

- **Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.**
- Prior authorization guidelines and quantity limits may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Proton Pump Inhibitors** and **Quantity Limits/Daily Dose Limits,** accessible on the Department's Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	# of pages: ________	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/State/Zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Preferred medication requested:
- ☐Nexium suspension packet
- ☐omeprazole Rx capsule
- ☐pantoprazole tablet
- ☐Protonix suspension packet

Non-preferred medication requested:
- ☐Aciphex tablet
- ☐Aciphex sprinkle
- ☐Dexilant capsule
- ☐esomeprazole magnesium DR capsule (generic Nexium Rx)
- ☐esomeprazole strontium capsule
- ☐lansoprazole OTC capsule
- ☐lansoprazole Rx capsule
- ☐Nexium Rx capsule
- ☐omeprazole OTC tablet
- ☐omeprazole magnesium OTC capsule
- ☐omeprazole/sodium bicarb Rx capsule
- ☐omeprazole/sodium bicarb Rx packet
- ☐Prevacid Rx capsule
- ☐Prevacid 24HR OTC capsule
- ☐Prevacid SoluTab
- ☐Prilosec Rx capsule
- ☐Prilosec suspension packet
- ☐Protonix tablet
- ☐rabeprazole tablet
- ☐Zegerid Rx capsule
- ☐Zegerid packet
- ☐________________________

Strength:	Directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

Will the PPI be administered via feeding tube? ☐Yes: tube type (NG, NJ, etc): __________ tube size (width): ____________ ☐No

Complete each section applicable to the requested medication.

Section A: ALL non-preferred requests

Question	Response	Documentation
1. Does the beneficiary have a history of trial and failure, contraindication, or intolerance to the preferred Proton Pump Inhibitors? *Check all that apply.* ☐Nexium suspension packet ☐pantoprazole tablet ☐omeprazole Rx capsule ☐Protonix suspension packet	☐Yes ☐No	*Submit all supporting documentation of medication name(s) and associated trial and failure, intolerance, and contraindications*

Section B: ALL requests (preferred and non-preferred) for beneficiaries UNDER THE AGE OF 6 YEARS

2. What is the beneficiary's weight? ____________________ pounds -or- ____________________ kilograms

Question	Response	Documentation
3. Has the beneficiary been on a PPI for more than 4 months?	☐Yes ☐No	*Submit documentation.*
4. Is the PPI prescribed by, or in consultation with, a gastroenterologist?	☐Yes ☐No	*Submit documentation of consultation, if applicable.*
5. Does the beneficiary have a chronic primary disease that requires chronic PPI therapy?	☐Yes ☐No	*Submit documentation.*
6. Did the beneficiary have a complete evaluation and diagnostic testing confirming a diagnosis that requires chronic PPI therapy?	☐Yes ☐No	*Submit documentation of evaluation and test results.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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