Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

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 provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Aciphex, Nexium, and omperazole and brand-name multiple-source proton pump inhibitors that have an FDA "A"-rated generic equivalent. PA is required for Prevacid for members older than 16 years old (except for use of Prevacid suspension for members in long-term-care facilities). Protonix does not require PA. Additional information about PPI use can be found within the MassHealth Drug List at **www.mass.gov/masshealth**.

Member information

Last name	First name	MI	MassHealth member ID #	Date of birth	Sex (Circle one.) f m

Member's place of residence ☐ home ☐ nursing facility

Indication for proton pump inhibitor

☐ **GERD**
- ☐ Moderate-severe erosive esophagitis
- ☐ Uncomplicated non-erosive esophagitis
  - Has an H_2 antagonist previously been tried?
  - ☐ Yes. State drug name, dose, frequency, and duration.
  - ☐ No. Explain why not.
- ☐ Barrett's esophagus or esophageal strictures
- ☐ 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**
- ☐ Non-cardiac chest pain ☐ Asthma
- ☐ Idiopathic hoarseness ☐ Chronic laryngitis
- ☐ Other (explain):

☐ **Duodenal ulcer** ☐ **Gastric ulcer**
- ☐ Helicobacter pylori:
  - ☐ Positive ☐ Negative
- ☐ Drug-induced:
  - ☐ Treatment: List causative agent(s):
  - ☐ Prevention: List risk factor(s):
- ☐ Other cause (specify):

☐ **Non-ulcer or functional dyspepsia**
- Has an H_2 antagonist previously been tried?
- ☐ Yes. State drug name, dose, frequency, and duration.
- ☐ No. Explain why not.

☐ **Pathological hypersecretory syndromes**
- ☐ Zollinger-Ellison syndrome
- ☐ MEN Type I
- ☐ Other:

☐ **Other** (explain):

over ▶

Diagnostic studies performed (include dates of studies)

Describe any diagnostic studies performed, including dates of studies.

Medication information

Important Note: For maximum efficacy, a proton pump inhibitor (PPI) must be taken in a fasting state, just before or with breakfast. If a second dose is necessary, the second dose should be given just before the evening meal. In general, it is not necessary to prescribe other antisecretory agents (H_2 antagonists, prostaglandins) for patients on PPIs. If an antisecretory agent is prescribed with a PPI, the PPI should not be taken within six hours of the antisecretory agent.

PPI requested	Dose, frequency, and duration of PPI	Drug or service code

Has member tried Protonix? (**Note:** Protonix does not require prior authorization.)

☐ Yes. Provide the following information about the use of Protonix.

Dates of use	Dose and frequency

If member received Protonix, why was it discontinued? (Check one or all that apply.)

☐ Adverse reaction ☐ Inadequate response ☐ Intolerance ☐ Other

Details of adverse reaction, inadequate response, intolerance, or other: _____

☐ No. Explain why not.

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date