Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

# I. Requirements for Prior Authorization of Proton Pump Inhibitors (PPIs)

## A. Prescriptions That Require Prior Authorization

Prescriptions for PPIs that meet any of the following conditions must be prior authorized:

1. A non-preferred PPI. See the Preferred Drug List (PDL) for the list of preferred PPIs at: https://papdl.com/preferred-drug-list.

2. A PPI for a child under 6 years of age when a PPI has been prescribed for a total of 4 months or more in the preceding 180-day period.

3. A PPI when there is a record of a recent paid claim for another drug within the same therapeutic class of drugs (therapeutic duplication).

## B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a PPI, the determination of whether the requested prescription is medically necessary will take into account the whether the beneficiary:

1. For a non-preferred PPI, has a history of therapeutic failure, contraindication, or intolerance to the preferred PPIs; **AND**

2. For a child under 6 years of age when a PPI has been prescribed for a total of 4 months or more in the preceding 180-day period, at least **one** of the following:

   a. Has a chronic primary disease such as cystic fibrosis, cerebral palsy, Down Syndrome, intellectual disability, or repaired esophageal atresia,
   b. Has documentation of a comprehensive evaluation and appropriate diagnostic testing confirming a diagnosis that requires chronic therapy,
   c. Is being prescribed the medication by or in consultation with a gastroenterologist;

   **AND**

3. For therapeutic duplication, **one** of the following:

   a. Is being titrated to or tapered from a drug in the same class
   b. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines;

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

## C. Clinical Review Process

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Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a PPI. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

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# PROTON PUMP INHIBITORS in CHILDREN < 6 YEARS OF AGE PRIOR AUTHORIZATION FORM

| | | | |
|---|---|---|---|
| ☐New request ☐Renewal request | # of pages: _____ | Prescriber name: | |
| Name of office contact: | | Specialty: | |
| Contact's phone number: | | NPI: | State license #: |
| LTC facility contact/phone: | | Street address: | |
| Beneficiary name: | | Suite #: | City/State/Zip: |
| Beneficiary ID#: | DOB: | Phone: | Fax: |
| Medication will be billed via: ☐ Pharmacy ☐ Medical (Jcode: ) | | Place of Service: ☐ Hospital ☐ Provider's Office ☐ Home ☐ Other | |

## CLINICAL INFORMATION

*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*

| | | |
|---|---|---|
| Drug requested: | 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 | | |
| What is the beneficiary's weight? _____ pounds -or- _____ kilograms | | |
| Has the beneficiary been on a PPI for more than 4 months? | ☐Yes ☐No | *Submit documentation.* |
| Is the PPI prescribed by or in consultation with a gastroenterologist? | ☐Yes ☐No | *Submit documentation of consultation, if applicable.* |
| Does the beneficiary have a chronic primary disease that requires chronic PPI therapy? | ☐Yes ☐No | *Submit documentation.* |
| 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.* |
| ***For a non-preferred PPI:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance to the preferred Proton Pump Inhibitors? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.* | ☐Yes ☐No | *Submit all supporting documentation of medication name(s) and associated trial and failure, intolerance, and contraindications* |

## PLEASE FAX COMPLETED FORM TO GATEWAY – PHARMACY DIVISION

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|---|---|
| **Prescriber Signature:** | **Date**: |