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 in CHILDREN < 6 YEARS OF AGE PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Proton Pump Inhibitors** and **Quantity Limits/Daily Dose Limits** are accessible on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐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:

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 WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: