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| Criteria 1 | Protonix Pak (P, AR, BvG), Pantoprazole Packet (NP, AR) |
| Criteria 2 | Non-Preferred: Aciphex, Dexilant (BvG), dexlansoprazole (BvG), Esomeprazole, Esomeprazole Granules (BvG), Konvomep, Lansoprazole ODT, Omeprazole/Sodium Bicarbonate, Prilosec Susp, Rabeprazole |
| Criteria 3 | Omeprazole Tab (NP, AR) |
| Criteria 4 | Omeprazole Cap, Pantoprazole Tab (P, AR) |

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| **Criteria Title** | | | Gastrointestinal Agents: Proton Pump Inhibitors | | | | | | |
| **Criteria Subtitle** | | | Protonix Pak, Pantoprazole Packet | | | | | | |
| **Approval Level** | | | GCNSeqNo | | | | | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | | | Drug Name | | Corresponding Code(s) | | Type of Code (GCNSeqNo, HICL, NDC) | | |
| PROTONIX PAK | | 063700 | | GCNSeqNo | | |
| PANTOPRAZOLE PACKET | | 063700 | | GCNSeqNo | | |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | | **Question Type** | | **Question Text** | | **Choice Text** | **Next Question ID** | |
| 1 | 0095 |  | | Select | | What product is being requested? | | Brand Protonix Pak | 0096 | |
| Generic pantoprazole packet | 0098 | |
| Other | 1235 | |
| 2 | 0096 |  | | Select | | Is the patient 6 years and older?  Please note: a PA is only required for patients 6 years and older. | | Y | 0097 | |
| N | 1237 | |
| 3 | 0097 |  | | Select and Free Text | | Is the patient unable to swallow a tablet and/or capsule formulation?  If yes, please submit documentation. | | Y | END (Approve x 180 days) | |
| N | 1235 | |
| 4 | 0098 |  | | Select | | Was the drug initiated in the hospital for the treatment of a condition such as a GI bleed or the presence of a gastrostomy and/or jejunostomy (G, GJ, J-tube)? | | Y | END (Approve x 180 days) | |
| N | 0099 | |
| 5 | 0099 |  | | Select | | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | | New Start (initial authorization request | 0100 | |
| Continuation (re-authorization request) | 1234 | |
| 6 | 0100 |  | | Select | | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | | Y | 0101 | |
| N | 1235 | |
| 7 | 0101 |  | | Select and Free Text | | Has the patient had an inadequate clinical response of at least 30 days with at least two preferred drugs?    If yes, please submit the medication trials and dates. | | Y | 0103 | |
| N | 0102 | |
| 8 | 0102 |  | | Select and Free Text | | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | | Y | 0103 | |
| N | 1236 | |
| 9 | 0103 |  | | Select and Free Text | | Has the brand medication been attempted and failed or is the brand medication contraindicated?  If yes, please submit documentation. | | Y | 0104 | |
| N | 1235 | |
| 10 | 0104 |  | | Select | | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | | Y | 0105 | |
| N | 0106 | |
| 11 | 0105 |  | | Select and Free Text | | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | | Y | 0106 | |
| N | 1235 | |
| 12 | 0106 |  | | Select | | Is the patient 6 years and older? | | Y | 0107 | |
| N | 1001 | |
| 13 | 0107 |  | | Select and Free Text | | Is the patient unable to swallow a tablet and/or capsule formulation?  If yes, please submit documentation. | | Y | 1001 | |
| N | 1235 | |
| 14 | 1001 |  | | Select | | Is the request for once daily or twice daily dosing? | | Once Daily Dosing | END (Pending Manual Review) | |
| Twice Daily Dosing | 1002 | |
| Other | 1235 | |
| 15 | 1002 |  | | Select | | Does the patient have a diagnosis of H. Pylori? | | Y | 1003 | |
| N | 1004 | |
| 16 | 1003 |  | | Select and Free Text | | Has the provider submitted documentation of the H. Pylori diagnosis?  If yes, please submit documentation. | | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 17 | 1004 |  | | Select | | What is the patient’s diagnosis? | | Carcinoma of GI Tract | 1005 | |
| COPD | 1005 | |
| Crest Syndrome | 1005 | |
| Dyspepsia | 1005 | |
| Esophageal Varices | 1005 | |
| Gastritis | 1005 | |
| Gastroparesis | 1005 | |
| Scleroderma | 1005 | |
| Symptomatic uncomplicated Barret’s Esophagus | 1005 | |
| Systemic Mastocytosis | 1005 | |
| Zollinger Ellison Syndrome | 1005 | |
| Other | 1005 | |
| 18 | 1005 |  | | Select and Free Text | | Has the provider submitted documentation of the patient’s diagnosis?  If yes, please submit documentation. | | Y | 1006 | |
| N | 1235 | |
| 19 | 1006 |  | | Select and Free Text | | Has the patient failed once daily dosing of the requested drug?    If yes, please submit documentation. | | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 20 | 1234 |  | | Select and Free Text | | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 21 | 1235 |  | | Free Text | | Please provide the rationale for the medication being requested. | | END (Pending Manual Review) | | |
| 22 | 1236 |  | | Free Text | | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | | END (Pending Manual Review) | | |
| 23 | 1237 |  | | Free Text | | A PA is not required for those younger than 6 years of age. | | END (Pending Manual Review) | | |

LENGTH OF AUTHORIZATIONS: Dependent on diagnosis

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| **Last Approved** | 8/11/2023 |
| **Other** |  |

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| **Criteria Title** | | | Gastrointestinal Agents: Proton Pump Inhibitors | | | | | | |
| **Criteria Subtitle** | | | Non-Preferred Products | | | | | | |
| **Approval Level** | | | GCNSeqNo | | | | | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | | | Drug Name | | | Corresponding Code(s) | | Type of Code (GCNSeqNo, HICL, NDC) | |
| ACIPHEX | | | 040941 | | GCNSeqNo | |
| DEXILANT | | | 064793 | | GCNSeqNo | |
| DEXILANT | | | 064794 | | GCNSeqNo | |
| DEXLANSOPRAZOLE DR 30 MG CAP | | | 064793 | | GCNSeqNo | |
| DEXLANSOPRAZOLE DR 60 MG CAP | | | 064794 | | GCNSeqNo | |
| ESOMPERAZOLE | | | 046649 | | GCNSeqNo | |
| ESOMEPRAZOLE | | | 047525 | | GCNSeqNo | |
| ESOMEPRAZOLE | | | 047526 | | GCNSeqNo | |
| ESOMEPRAZOLE GRANULES | | | 062245 | | GCNSeqNo | |
| ESOMEPRAZOLE GRANULES | | | 062246 | | GCNSeqNo | |
| ESOMEPRAZOLE GRANULES | | | 063668 | | GCNSeqNo | |
| KONVOMEP | | | 083784 | | GCNSeqNo | |
| LANSOPRAZOLE ODT | | | 051653 | | GCNSeqNo | |
| LANSOPRAZOLE ODT | | | 051654 | | GCNSeqNo | |
| OMEPRAZOLE/SODIUM BICARBONATE | | | 060471 | | GCNSeqNo | |
| OMEPRAZOLE/SODIUM BICARBONATE | | | 060472 | | GCNSeqNo | |
| OMEPRAZOLE/SODIUM BICARBONATE | | | 060473 | | GCNSeqNo | |
| OMEPRAZOLE/SODIUM BICARBONATE | | | 060474 | | GCNSeqNo | |
| PRILOSEC SUSP | | | 064774 | | GCNSeqNo | |
| PRILOSEC SUSP | | | 064775 | | GCNSeqNo | |
| RABEPRAZOLE | | | 040941 | | GCNSeqNo | |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | | **Question Type** | **Question Text** | | **Choice Text** | | **Next Question ID** | |
| 1 | 0098 |  | | Select | Was the drug being requested initiated in the hospital for the treatment of a condition such as a GI bleed or the presence of a gastrostomy and/or jejunostomy (G, GJ, J-tube)? | | Y | | END (Approve x 180 days) | |
| N | | 0099 | |
| 2 | 0099 |  | | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | | New Start (initial authorization request | | 0100 | |
| Continuation (re-authorization request) | | 1234 | |
| 3 | 0100 |  | | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | | Y | | 0101 | |
| N | | 1235 | |
| 4 | 0101 |  | | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days with at least two preferred drugs?    If yes, please submit the medication trials and dates. | | Y | | 0103 | |
| N | | 0102 | |
| 5 | 0102 |  | | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | | Y | | 0103 | |
| N | | 1236 | |
| 6 | 0103 |  | | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | | Y | | 0104 | |
| N | | 0105 | |
| 7 | 0104 |  | | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | | Y | | 0105 | |
| N | | 1235 | |
| 8 | 0105 |  | | Select | Is the request for any of the following products:  Brand Dexilant, generic dexlansoprazole, or generic esomeprazole granules? | | Y | | 0106 | |
| N | | 1001 | |
| 9 | 0106 |  | | Select | Which drug is being requested? | | Brand Dexilant | | 1001 | |
| Generic dexlansoprazole | | 0107 | |
| Generic esomeprazole granules | | 0107 | |
| Other | | 1235 | |
| 10 | 0107 |  | | Select and Free Text | Has the brand medication been attempted and failed or is the brand medication contraindicated?  If yes, please submit documentation. | | Y | | 1001 | |
| N | | 1235 | |
| 11 | 1001 |  | | Select | Is the request for once daily or twice daily dosing? | | Once Daily Dosing | | END (Approve x 180 days) | |
| Twice Daily Dosing | | 1002 | |
| Other | | 1235 | |
| 12 | 1002 |  | | Select | Does the patient have a diagnosis of H. Pylori? | | Y | | 1003 | |
| N | | 1004 | |
| 13 | 1003 |  | | Select and Free Text | Has the provider submitted documentation of the H. Pylori diagnosis?  If yes, please submit documentation. | | Y | | END (Pending Manual Review) | |
| N | | 1235 | |
| 14 | 1004 |  | | Select | What is the patient’s diagnosis? | | Carcinoma of GI Tract | | 1005 | |
| COPD | | 1005 | |
| Crest Syndrome | | 1005 | |
| Dyspepsia | | 1005 | |
| Esophageal Varices | | 1005 | |
| Gastritis | | 1005 | |
| Gastroparesis | | 1005 | |
| Scleroderma | | 1005 | |
| Symptomatic uncomplicated Barret’s Esophagus | | 1005 | |
| Systemic Mastocytosis | | 1005 | |
| Zollinger Ellison Syndrome | | 1005 | |
| Other | | 1005 | |
| 15 | 1005 |  | | Select and Free Text | Has the provider submitted documentation of the patient’s diagnosis?  If yes, please submit documentation. | | Y | | 1006 | |
| N | | 1235 | |
| 16 | 1006 |  | | Select and Free Text | Has the patient failed once daily dosing of the requested drug?    If yes, please submit documentation. | | Y | | END (Pending Manual Review) | |
| N | | 1235 | |
| 17 | 1234 |  | | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | | Y | | END (Pending Manual Review) | |
| N | | 1235 | |
| 18 | 1235 |  | | Free Text | Please provide the rationale for the medication being requested. | | END (Pending Manual Review) | | | |
| 19 | 1236 |  | | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | | END (Pending Manual Review) | | | |

LENGTH OF AUTHORIZATIONS: Dependent on diagnosis

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| **Last Approved** | 8/11/2023 |
| **Other** |  |

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| **Criteria Title** | | | Gastrointestinal Agents: Proton Pump Inhibitors | | | | | | |
| **Criteria Subtitle** | | | Omeprazole Tab | | | | | | |
| **Approval Level** | | | GCNSeqNo | | | | | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | | | Drug Name | | | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) | | |
| OMEPRAZOLE TAB | | | 054334 | GCNSeqNo | | |
| OMEPRAZOLE TAB | | | 025703 | GCNSeqNo | | |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | | **Question Type** | **Question Text** | | | **Choice Text** | **Next Question ID** | |
| 1 | 0098 |  | | Select | Was the drug being requested initiated in the hospital for the treatment of a condition such as a GI bleed or the presence of a gastrostomy and/or jejunostomy (G, GJ, J-tube)? | | | Y | END (Approve x 180 days) | |
| N | 0099 | |
| 2 | 0099 |  | | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | | | New Start (initial authorization request) | 0100 | |
| Continuation (re-authorization request) | 1234 | |
| 3 | 0100 |  | | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | | | Y | 0101 | |
| N | 1235 | |
| 4 | 0101 |  | | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days with at least two preferred drugs?    If yes, please submit the medication trials and dates. | | | Y | 0103 | |
| N | 0102 | |
| 5 | 0102 |  | | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?    If yes, please submit the medication name and reason for inability to use. | | | Y | 0103 | |
| N | 1236 | |
| 6 | 0103 |  | | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | | | Y | 0104 | |
| N | 1000 | |
| 7 | 0104 |  | | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | | | Y | 1000 | |
| N | 1235 | |
| 8 | 1000 |  | | Select | Is the patient 21 years and older? | | | Y | 1001 | |
| N | END (Approve x 180 days) | |
| 9 | 1001 |  | | Select | Is the request for once daily or twice daily dosing? | | | Once Daily Dosing | END (Approve x 180 days) | |
| Twice Daily Dosing | 1002 | |
| Other | 1235 | |
| 10 | 1002 |  | | Select | Does the patient have a diagnosis of H. Pylori? | | | Y | 1003 | |
| N | 1004 | |
| 11 | 1003 |  | | Select and Free Text | Has the provider submitted documentation of the H. Pylori diagnosis?  If yes, please submit documentation. | | | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 12 | 1004 |  | | Select | What is the patient’s diagnosis? | | | Carcinoma of GI Tract | 1005 | |
| COPD | 1005 | |
| Crest Syndrome | 1005 | |
| Dyspepsia | 1005 | |
| Esophageal Varices | 1005 | |
| Gastritis | 1005 | |
| Gastroparesis | 1005 | |
| Scleroderma | 1005 | |
| Symptomatic uncomplicated Barret’s Esophagus | 1005 | |
| Systemic Mastocytosis | 1005 | |
| Zollinger Ellison Syndrome | 1005 | |
| Other | 1005 | |
| 13 | 1005 |  | | Select and Free Text | Has the provider submitted documentation of the patient’s diagnosis?  If yes, please submit documentation. | | | Y | 1006 | |
| N | 1235 | |
| 14 | 1006 |  | | Select and Free Text | Has the patient failed once daily dosing of the requested drug?  If yes, please submit documentation. | | | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 15 | 1234 |  | | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | | | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 16 | 1235 |  | | Free Text | Please provide the rationale for the medication being requested. | | | END (Pending Manual Review) | | |
| 17 | 1236 |  | | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | | | END (Pending Manual Review) | | |

LENGTH OF AUTHORIZATIONS: Dependent on diagnosis

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| **Last Approved** | 8/11/2023 |
| **Other** |  |

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| **Criteria Title** | | | Gastrointestinal Agents: Proton Pump Inhibitors | | | | | | | |
| **Criteria Subtitle** | | | Omeprazole Cap, Pantoprazole Tab | | | | | | | |
| **Approval Level** | | | GCNSeqNo | | | | | | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | | | Drug Name | | | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) | | | |
| OMEPRAZOLE CAP | | | 066403 | GCNSeqNo | | | |
| OMEPRAZOLE CAP | | | 033530 | GCNSeqNo | | | |
| OMEPRAZOLE CAP | | | 043136 | GCNSeqNo | | | |
| OMEPRAZOLE CAP | | | 043137 | GCNSeqNo | | | |
| PANTOPRAZOLE TAB | | | 027462 | GCNSeqNo | | | |
| PANTOPRAOZLE TAB | | | 039545 | GCNSeqNo | | | |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | | **Question Type** | **Question Text** | | | **Choice Text** | **Next Question ID** |
| 1 | 0999 |  | | Select | Is the patient 21 years and older? | | | Y | 1000 |
| N | 1236 |
| 2 | 1000 |  | | Select | Is the request for once daily or twice daily dosing? | | | Once Daily Dosing | 1237 |
| Twice Daily Dosing | 1001 |
| Other | 1235 |
| 3 | 1001 |  | | Select | Was the drug being requested initiated in the hospital for the treatment of a condition such as a GI bleed or the presence of a gastrostomy and/or jejunostomy (G, GJ, J-tube)? | | | Y | END (Approve x 180 days) |
| N | 1002 |
| 4 | 1002 |  | | Select | Does the patient have a diagnosis of H. Pylori? | | | Y | 1003 |
| N | 1004 |
| 5 | 1003 |  | | Select and Free Text | Has the provider submitted documentation of the H. Pylori diagnosis?    If yes, please submit documentation. | | | Y | END (Pending Manual Review) |
| N | 1235 |
| 6 | 1004 |  | | Select | What is the patient’s diagnosis? | | | Carcinoma of GI Tract | 1005 |
| COPD | 1005 |
| Crest Syndrome | 1005 |
| Dyspepsia | 1005 |
| Esophageal Varices | 1005 |
| Gastritis | 1005 |
| Gastroparesis | 1005 |
| Scleroderma | 1005 |
| Symptomatic uncomplicated Barret’s Esophagus | 1005 |
| Systemic Mastocytosis | 1005 |
| Zollinger Ellison Syndrome | 1005 |
| Other | 1005 |
| 7 | 1005 |  | | Select and Free Text | Has the provider submitted documentation of the patient’s diagnosis?  If yes, please submit documentation. | | | Y | 1006 |
| N | 1235 |
| 8 | 1006 |  | | Select and Free Text | Has the patient failed once daily dosing of the requested drug?  If yes, please submit documentation. | | | Y | END (Pending Manual Review) |
| N | 1235 |
| 9 | 1235 |  | | Free Text | Please provide the rationale for the medication being requested. | | | END (Pending Manual Review) | |
| 10 | 1236 |  | | Free Text | A PA is not required for those younger than 21 years old. | | | END (Pending Manual Review) | |
| 11 | 1237 |  | | Free Text | A PA is not required for those requesting once daily dosing. | | | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: Dependent on diagnosis

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| **Last Approved** | 8/11/2023 |
| **Other** |  |