TO: Pharmacy Providers, Physicians, Nurse Practitioners, Dental Providers, Physician Assistants, Optometrists, Long Term Care Providers, Clinics, and Hospitals
RE: New Prior Authorization Criteria for Proton Pump Inhibitors (PPIs)

The Department of Social Services (DSS) is implementing new Prior Authorization (PA) criteria for Proton Pump Inhibitors (PPIs), effective July 1, 2013. The new criteria resembles a step therapy approach which requires that patients have a documented treatment failure to one of the preferred PPIs identified on the Preferred Drug List (PDL) as efficacious, safe and cost effective by the State of Connecticut's Pharmaceutical and Therapeutics Committee. The new criteria will impact members of the HUSKY A, HUSKY C, and HUSKY D benefit plans. DSS will be expanding step therapy to additional classes in the future, but at no point will step therapy extend to mental health drugs. Additionally, the epilepsy legislation passed in 2011 will remain in effect (refer to Section 20-619 (i) of CT General Statutes).

Effective July 1, 2013, the newly developed Proton Pump Inhibitor Prior Authorization (PPI PA) Request Form **must** be used to request a PA for any non-preferred PPI. The PPI PA form requires prescribers to explain why the client cannot be treated with one of the currently preferred agents. (A preferred PPI should be tried for a minimum of 30 days before a non-preferred PPI is requested). The prescriber must indicate which preferred product has been utilized in the past, select a reason for the failure, and supply a specific written clinical explanation of the failure. The allowable reasons that may be indicated on the form are:

- Use of the formulary alternative is contraindicated (e.g. due to hypersensitivity);
- The patient has experienced significant adverse effects from the formulary alternative;
- Use of the formulary alternative has resulted in therapeutic failure; or
- Pediatric patient (the patient is younger than 12 years of age).

Providers are urged to be proactive in switching members to a preferred medication when medically appropriate. If a claim for a non-preferred PPI is submitted by a pharmacy and no PA is on file, the pharmacy will receive a message stating that they should contact the prescriber.

The pharmacist should consult with the prescriber to see if a preferred drug can be prescribed as an alternative, or explain that the prescriber must obtain the PPI PA from HP before a non-preferred PPI can be dispensed.

If PA is required and it has not been requested/approved, the pharmacy can dispense a one-time 14 day fill. In addition, the pharmacy is required to provide the client with a copy of the 14-day flier which was sent to pharmacies on September 12, 2012 (PB12-41).

Please note: the Department will honor previous authorizations for PPIs approved prior to July 1, 2013 for dates of service on or after July 1, 2013 up to a period of one year.

The new PPI PA form is attached to this bulletin and can also be found on the

http://www.ctdssmap.com Web site. From the Home page, go to Information → Publications → Forms → Authorization/Certification Forms → Proton Pump Inhibitor PA Form; or to Pharmacy Information → Pharmacy Program Publications → Proton Pump Inhibitor PA Form.

STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
PROTON PUMP INHIBITOR PRIOR AUTHORIZATION REQUEST FORM
[This and other pharmacy PA forms are available on the www.ctdssmap.com Web site]
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110 OR (860) 269-2035
PO BOX 2943 HARTFORD, CT 06104

Prior Authorization Criteria for Proton Pump Inhibitors (PPIs)

- The Pharmacy Call Center team will validate the client's history for preferred agent(s) before an approval for a non- preferred agent will be authorized. Non-Preferred PPIs will be approved when it is indicated by the Medical History that the patient has tried and failed a normal course of therapy with at least one preferred PPI.
- For clients new to Medicaid, a pharmacy profile showing previously failed preferred products, outcomes and compliance with the medication should be provided with the non-preferred product request form.
- Clinical prior authorization must be obtained for any non-preferred PPI using this form only, not the standard non-PDL PA form.
- Proton Pump Inhibitors are antisecretory compounds. They do not exhibit anticholinergic or histamine (H2) antagonistic properties, but suppress gastric acid secretion which may interfere with the absorption of other agents.

Prescriber and Member Information

Please note: incomplete requests will be denied.

1. Prescriber's Name (Last, First)	5. Member's Name (Last, First)
2. Prescriber's NPI	6. Member's ID
3. Prescriber's Phone	7. Member's Date of Birth (MM/DD/CCYY)
4. Prescriber's Fax	8. Pharmacy's Name & Fax

9. Drug Requested (circle): Aciphex Dexilant Lansoprazole Nexium Omeprazole
Omeprazole/sodium bicarbonate Pantoprazole Prevacid Prilosec Protonix

10. Dosage Form: ☐ Capsule / Tablet ☐ Packet ☐ Solutab ☐ Suspension

11. Strength 12. Quantity 13. Frequency of Dosing

Medical History

Please note: incomplete requests will be denied.

Please explain why the patient cannot be treated with a preferred alternative. You MUST indicate which preferred product has been utilized in the past, circle a reason for the failure (listed below), AND supply a specific written clinical explanation.

14. Preferred Product Name & Daily Dose	**15. Reason**	**16. Clinical Explanation (including length of therapy and outcome)**
	1 2 3 4	

1. Use of the preferred alternative is contraindicated.
2. The patient has experienced significant adverse effects from the preferred alternative, FDA 3500 MedWatch Form filed.
3. Use of the preferred alternative has resulted in therapeutic failure after the course of treatment.
4. Pediatric patient (the patient is younger than 12 years of age).

I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under Connecticut Gen. Stat. Section 17b-99 and Regs. Conn. State Agencies Sections 17-83k-1-3 and 4a –7, inclusive. I certify that the client is under my clinic's/practice's ongoing care.

17. Signature of Prescriber* _____ 18. Date (MMDDCCYY) _____

*** Mandatory (others may not sign for prescriber).** As a result of the Affordable Care Act (ACA), prescribing providers are required to be enrolled as an ordering, prescribing, or referring provider in the CT Medical Assistance Program.

No.	Name	Description
1.	Prescriber's Name (Last, First)	Enter the prescribing practitioner's last name and first name
2.	Prescriber's NPI	Enter the prescribing practitioner's National Provider Identification (NPI) number
3.	Prescriber's Phone	Enter the prescribing practitioner's phone number where a PA customer service representative can contact the practitioner for additional information or clarification, if necessary
4.	Prescriber's Fax	Enter the prescribing practitioner's fax number where a PA customer service representative can contact the practitioner for additional information or clarification, if necessary
5.	Member's Name (Last, First)	Enter the member's name as it appears on the member's CONNECT Card or as obtained from the Automated Eligibility Verification System (AEVS)
6.	Member's ID	Enter the member's 9-digit identification number as it appears on the member's CONNECT Card or as obtained from the Automated Eligibility Verification System (AEVS)
7.	Member's Date of Birth (MMDDCCYY)	Enter the member's date of birth in MM/DD/CCYY format
8.	Pharmacy's Name & Fax (optional)	Enter the pharmacy's name and fax number, if known
9.	Drug Requested	Circle the drug for which the Prior Authorization is being requested
10.	Dosage Form	Select the dosage form of the drug being requested
11.	Strength	Enter the strength of the drug in milligrams
12.	Quantity	Enter the quantity of the drug being prescribed
13.	Frequency of Dosing	Enter the dosing frequency
14.	Preferred Product	Indicate which preferred PPI the patient has tried and failed in the past including dose/day
15.	Reason	Circle the number on the form which corresponds to the type of failure experienced
16.	Clinical Explanation	Provide a written clinical explanation of the indicated failure to a preferred product including length of therapy and outcome
17.	Signature of Prescriber	The prescribing practitioner must sign the PA form; agent's signature is not acceptable
18.	Date (MMDDCCYY)	Enter the date the form was completed, signed, and submitted in MM/DD/CCYY format