Clinical Policy: Proton Pump Inhibitors (PPIs)

Reference Number: PHW.PDL.047
Effective Date: 01/01/2020
Last Review Date: 11/2025

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of PA Health & Wellness® that Proton Pump Inhibitors (PPIs) are **medically necessary** when the following criteria are met:

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.
2. A PPI with a prescribed quantity that exceeds the quantity limit.
3. A PPI for a child under six (6) years of age when a PPI has been prescribed for a total of four (4) months in the preceding 180-day period.
4. An over-the-counter (OTC) PPI for a dual-eligible member, regardless of the quantity prescribed.
5. 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 member:

1. Is prescribed the requested PPI for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication; **AND**
2. Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
3. For a non-preferred PPI, has a history of therapeutic failure of a contraindication or an intolerance to the preferred PPIs; **AND**

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

    a. Has a chronic primary disease such as cystic fibrosis, cerebral palsy, DownSyndrome, 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 drug by or in consultation with a gastroenterologist;

    AND

5. For an OTC PPI for a dual-eligible member, **both** of the following:

    a. Is not being prescribed the OTC PPI as part of a Medicare Part D plan utilization management program, including a step-therapy or prior authorization program
    b. Has a history of therapeutic failure of or a contraindication or an intolerance to the PPI on the member's Medicare Part D plan formulary;

    AND

6. 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 drugs that is supported by peer-reviewed literature or national treatment guidelines;

    AND

7. If a prescription for a PPI is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

    NOTE: If the member 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 member, the request for prior authorization will be approved.

C. Clinical Review Process

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 member.

D. **Approval Duration: 12 months**

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021 annual review: no changes.	01/2021
Q1 2022 annual review: no changes.	11/2021
Q1 2023 annual review: no changes.	11/2022
Q1 2024 annual review: no changes.	11/2023
Q1 2025 annual review: no changes.	11/2024
Q1 2026: policy revised according to DHS revisions effective 01/05/2026.	11/2025