Pharmacy Medical Necessity Guidelines:
Sucralfate oral suspension

Effective: September 15, 2026

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM
These pharmacy medical necessity guidelines apply to the following: ☒ Tufts Health RITogether – A Rhode Island Medicaid Plan		**Fax Numbers:** RXUM: 617.673.0939	

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FDA-APPROVED INDICATIONS

Sucralfate (Carafate) oral suspension is approved for the short-term treatment (i.e., 8 weeks) of active duodenal ulcers not related to NSAID use.

Tufts Health RITogether coverages sucralfate oral suspension for all Members 11 years of age and younger; prior authorization is required for members 12 years of age and older. Sucralfate tablet is covered for all Members without prior authorization.

COVERAGE GUIDELINES

For members 12 years of age and older, the plan may authorize coverage of sucralfate oral suspension when **ALL** of the following criteria for a particular regimen are met and limitations do not apply:

1. Member has had an inadequate response, intolerance, or contraindication to generic sucralfate tablets

OR

2. Rationale why treatment with generic sucralfate tablets is clinically inappropriate

LIMITATIONS

1. Requests for brand-name products, with AB-rated generics, will also be reviewed according to the Brand name criteria.

CODES

None

REFERENCES

1. Carafate® (sucralfate oral suspension) [prescribing information]. Madison, NJ: Allergan, USA, Inc.; January 2023.

APPROVAL HISTORY

October 11, 2022: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. September 12, 2023: Effective December 1, 2023, updated MNG title from "Carafate" to "Sucralfate" to reflect generic preference. Updated previous trial language to state "inadequate response, intolerance, or contraindication to."
2. September 10, 2024: No criteria changes. Administrative change to fax number.
3. September 9, 2025: No changes
4. September 15, 2026: No changes.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical

Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

Provider Services