



# Prior Authorization Request Administrative Information

## Member information

Last name  First name  MI

Member ID  Date of birth

Sex assigned at birth  Female  Male  "X" or Intersex

Current gender  Female  Male  Transgender male  Transgender female  Other

Place of residence  Home  Nursing facility  Other

Race  Ethnicity

Preferred spoken language  Preferred written language

MassHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, creed, sexual orientation, or sex (including gender identity and gender stereotyping).

## Plan contact information

Please indicate the member's MassHealth Plan and fax or submit this completed and signed form according to the Plan's contact information below.

<b>MassHealth Fee-For-Service (FFS) Plan, Primary Care Clinician (PCC) Plan, Primary Care Accountable Care Organization (PCACO) Plan, and Children's Medical Security Plan</b>
<input type="checkbox"/> <b>MassHealth Drug Utilization Review Program</b> Pharmacy: Fax: (877) 208-7428 - Tel: (800) 745-7318
<b>MassHealth Managed Care Organization (MCO) and Accountable Care Partnership Plans (ACPP)</b>
<input type="checkbox"/> <b>Fallon Health</b> Online Prior Authorization: <a href="http://go.covermymeds.com/OptumRx">go.covermymeds.com/OptumRx</a> Online Prior Authorization: <a href="http://providerportal.surescripts.net/ProviderPortal/optum">providerportal.surescripts.net/ProviderPortal/optum</a> Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033
<input type="checkbox"/> <b>Health New England</b> Online Prior Authorization: <a href="http://go.covermymeds.com/OptumRx">go.covermymeds.com/OptumRx</a> Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545
<input type="checkbox"/> <b>Mass General Brigham Health Plan</b> Online Prior Authorization (Pharmacy Benefit Reviews): <a href="http://go.covermymeds.com/OptumRx">go.covermymeds.com/OptumRx</a> Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555 Online Prior Authorization (Medical Specialty Reviews): <a href="http://provider.massgeneralbrighamhealthplan.org">provider.massgeneralbrighamhealthplan.org</a> Medical Specialty Reviews: Fax: (888) 656-6671 - Tel: (833) 895-2611
<input type="checkbox"/> <b>Tufts Health Plan</b> Online Prior Authorization: <a href="http://point32health.promptpa.com">point32health.promptpa.com</a> Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985
<input type="checkbox"/> <b>WellSense Health Plan</b> Online Prior Authorization: <a href="http://wellsense.org/providers/ma/pharmacy/prior-authorizations">wellsense.org/providers/ma/pharmacy/prior-authorizations</a> Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822

# Nonsteroidal Anti-Inflammatory Drugs (NSAID) Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at [www.mass.gov/druglist](http://www.mass.gov/druglist).

## Medication information

**Medication requested** (Check one or all that apply. Where applicable, the brand name is provided in brackets for reference.)

- |                                                                   |                                                                  |
|-------------------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Coxanto (oxaprozin capsule)              | <input type="checkbox"/> ketorolac > 20 units/30 days            |
| <input type="checkbox"/> diclofenac 25 mg capsule                 | <input type="checkbox"/> ketorolac nasal spray                   |
| <input type="checkbox"/> diclofenac/misoprostol < 60 years of age | <input type="checkbox"/> meclofenamate                           |
| <input type="checkbox"/> diclofenac potassium 25 mg tablet        | <input type="checkbox"/> meloxicam capsule                       |
| <input type="checkbox"/> diclofenac powder for solution           | <input type="checkbox"/> naproxen controlled-release             |
| <input type="checkbox"/> diclofenac topical patch                 | <input type="checkbox"/> naproxen suspension < 13 years of age   |
| <input type="checkbox"/> diflunisal 250 mg, 375 mg tablet         | <input type="checkbox"/> naproxen/esomeprazole < 60 years of age |
| <input type="checkbox"/> Elyxyb (celecoxib oral solution)         | <input type="checkbox"/> Relafen DS (nabumetone 1000 mg)         |
| <input type="checkbox"/> etodolac extended-release                | <input type="checkbox"/> salsalate                               |
| <input type="checkbox"/> fenoprofen                               | <input type="checkbox"/> tolmetin                                |
| <input type="checkbox"/> ibuprofen/famotidine < 60 years of age   | <input type="checkbox"/> Zybic (meloxicam suspension)            |
| <input type="checkbox"/> indomethacin suppository                 | <input type="checkbox"/> Other* <input type="text"/>             |
| <input type="checkbox"/> indomethacin suspension                  |                                                                  |
| <input type="checkbox"/> ketoprofen extended-release              |                                                                  |

**Dose, frequency, and duration of medication requested**

**Indication or ICD-10 code, if applicable**

*\* If request is for a non-preferred brand name or generic product, please attach supporting documentation (e.g., copies of medical records and/or office notes regarding adverse reaction or inadequate response to the preferred product).*

## Section I. Please complete for topical product requests.

Has the member tried diclofenac 1% gel?

Yes. Please complete Section V.

No. Please indicate why not.

## Section II. Please complete for Coxanto, controlled-release products, extended-release products, solution products, orally disintegrating products, suspension products, and suppositories.

1. Please provide medical necessity for the use of the requested formulation.

  

2. For Coxanto, has the member tried two other different NSAIDs?

Yes. Please complete Section V.

No. Please indicate why not.

1. For diclofenac powder for solution, has the member tried naproxen suspension?  
 Yes. Please complete Section V.  
 No. Please indicate why not.
2. For Elyxyb, has the member tried celecoxib capsules?  
 Yes. Please complete Section V.  
 No. Please indicate why not.
3. For indomethacin suspension and naproxen suspension products, has the member tried ibuprofen suspension?  
 Yes. Please complete Section V.  
 No. Please indicate why not.
4. For indomethacin suppositories, has the member tried ibuprofen suppositories?  
 Yes. Please complete Section V.  
 No. Please indicate why not.
5. For Zybic (meloxicam suspension), has the member tried both ibuprofen suspension and naproxen suspension?  
 Yes. Please complete Section V.  
 No. Please indicate why not.

**Section III. Please complete for diclofenac/misoprostol, ibuprofen/famotidine, ketorolac nasal spray, naproxen/esomeprazole, and Relafen DS requests.**

A trial with concurrent therapy of diclofenac and misoprostol is required for diclofenac/misoprostol requests. A trial of ketorolac tablets or injection is required for ketorolac nasal spray requests. A trial with concurrent therapy of ibuprofen and famotidine is required for ibuprofen/famotidine requests. A trial with concurrent therapy of naproxen and omeprazole is required for naproxen/esomeprazole requests. A trial of an equivalent dose of nabumetone 500 mg or 750 mg is required for Relafen DS requests.

**Section IV. Please complete for diflunisal tablet and fenoprofen capsule requests.**

1. For diflunisal 250 mg or 375 mg tablet, has the member tried diflunisal 500 mg tablet?  
 Yes. Please complete Section V.  
 No. Please indicate why not.
2. For fenoprofen 300 mg capsules, has the member tried fenoprofen 400 mg capsules?  
 Yes. Please complete Section V.  
 No. Please indicate why not.

**Section V. Please complete for all requests as needed.**

Please provide the following information regarding previous NSAID trials.\*

Drug name  Dates/duration of use

Did the member experience any of the following?  Adverse reaction  Inadequate response  Other

Details of adverse reaction, inadequate response, or other.

Drug name  Dates/duration of use

Did the member experience any of the following?  Adverse reaction  Inadequate response  Other

Details of adverse reaction, inadequate response, or other.

Drug name  Dates/duration of use

Did the member experience any of the following?  Adverse reaction  Inadequate response  Other

Details of adverse reaction, inadequate response, or other.

*\* Please attach a letter documenting additional trials as necessary.*

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**Section VI. Please complete for ketorolac requests exceeding the quantity limit.**

Please describe the medical necessity for exceeding the quantity limit.

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**Section VII. Please complete and provide documentation for exceptions to step therapy.**

1. Is the alternative drug required under the step therapy protocol contraindicated, or will likely cause an adverse reaction in, or physical or mental harm to, the member?  Yes  No

If yes, briefly describe details of contraindication, adverse reaction, or harm.

2. Is the alternative drug required under the step therapy protocol expected to be ineffective based on the known clinical characteristics of the member and the known characteristics of the alternative drug regimen?  Yes  No

If yes, briefly describe details of known clinical characteristics of member and alternative drug regimen.

3. Has the member previously tried the alternative drug required under the step therapy protocol, or another alternative drug in the same pharmacologic class or with the same mechanism of action, and such alternative drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?  Yes  No

If yes, please provide details for the previous trial.

Drug name  Dates/duration of use

Did the member experience any of the following?  Adverse reaction  Inadequate response

Briefly describe details of adverse reaction or inadequate response.

4. Is the member stable on the requested prescription drug prescribed by the health care provider, and switching drugs will likely cause an adverse reaction in, or physical or mental harm to, the member?

Yes. Please provide details.

No

# Prior Authorization Request Prescriber and Provider Information

## Prescriber information

Last name*	<input type="text"/>	First name*	<input type="text"/>	MI	<input type="text"/>
NPI*	<input type="text"/>	Individual MH Provider ID	<input type="text"/>		
DEA No.	<input type="text"/>	Office Contact Name	<input type="text"/>		
Address	<input type="text"/>	City	<input type="text"/>	State	<input type="text"/>
E-mail address	<input type="text"/>				
Telephone No.*	<input type="text"/>				
Fax No.* (Please provide fax number for PA response notification.)	<input type="text"/>				

\* Required

## Please also complete for professionally administered medications, if applicable.

Start date	<input type="text"/>	End date	<input type="text"/>		
Servicing prescriber/facility name	<input type="text"/>	<input type="checkbox"/>	Same as prescribing provider		
Servicing provider/facility address	<input type="text"/>				
Servicing provider NPI/tax ID No.	<input type="text"/>				
Name of billing provider	<input type="text"/>				
Billing provider NPI No.	<input type="text"/>				
Is this a request for recertification?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
CPT code	<input type="text"/>	No. of visits	<input type="text"/>	J code	<input type="text"/>
				No. of units	<input type="text"/>

## Provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am either the prescribing provider or duly authorized to act on behalf of the provider identified in the Prescriber information section of this form. Any attached statement on letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

### Signature of provider or individual duly authorized to act on behalf of the provider:

Printed legal name and title of signatory above

<input type="text"/>	Date	<input type="text"/>
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(The form can either be signed by hand and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.)