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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.

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

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Opioids/Acetaminophen Analgesic
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 opioid and acetaminophen analgesic agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist**.

Medication information

Drug name _____ **Dose and frequency** _____ **Duration of therapy** _____

Indication or ICD-10 code, if applicable _____

Has the prescriber evaluated Massachusetts Prescription Awareness Tool (MassPAT) data, risk factors, and potential risk factors for abuse/misuse in their assessment of this member? ☐ Yes ☐ No

Has the member been offered and/or given a prescription for naloxone treatment?

☐ Yes ☐ No. Please provide details. _____

For mid-level practitioners (e.g., nurse practitioners, physician assistants), please provide the name and specialty of the collaborating physician. _____

Is this member a referral candidate for care coordination? ☐ Yes ☐ No

If yes, MassHealth will offer care coordination services to this member. Please describe which additional behavioral health service would be beneficial. *Please inform the member, parent, or legal guardian to expect outreach from a MassHealth representative of care coordination services.*

_____

Section I. Please complete for oxycodone extended-release (ER) tablet (Oxycontin) requests.*

Has the member tried a morphine extended-release product or a fentanyl transdermal product?

☐ Yes. Drug _____ Dose and frequency _____

Dates of use _____ Outcome _____

☐ No. If morphine and fentanyl transdermal are contraindicated in this member, please describe. _____

_____

Section II. Please complete for methadone (Methadose) requests.*

1. Has the member tried a morphine extended-release product?

   ☐ Yes. Dose and frequency _____ Dates of use _____ Outcome _____

   ☐ No. If morphine is contraindicated in this member, please describe. _____

   _____

2. Has the member tried a fentanyl transdermal product?

   ☐ Yes. Dose and frequency _____ Dates of use _____ Outcome _____

☐ No. If fentanyl transdermal is contraindicated in this member, please describe.

3. If the answer to questions 1 and 2 is no, please provide clinical rationale for the use of methadone instead of other long-acting opioids.
4. Is the member opioid naive? ☐ Yes ☐ No
5. Has the member had a baseline ECG showing a normal QTc interval? ☐ Yes ☐ No

Section III. Please complete for requests for fentanyl buccal tablet, fentanyl transmucosal system, oxymorphone immediate-release (IR), and tapentadol.*

1. Has the member tried the following agents? ☐ Yes. Please describe below.

hydromorphone IR Dose and frequency Dates of use Outcome

morphine IR Dose and frequency Dates of use Outcome

oxycodone IR Dose and frequency Dates of use Outcome

☐ No. If hydromorphone, morphine, and oxycodone are contraindicated in this member, please describe.

2. For fentanyl buccal tablet requests, has the member tried fentanyl transmucosal system?

☐ Yes. Dose and frequency Dates of use Outcome

☐ No. If fentanyl transmucosal system is contraindicated in this member, please describe.

3. For fentanyl buccal tablet and transmucosal system requests, is the member currently maintained on a long-acting opioid regimen?

☐ Yes. Drug Dose and frequency Dates of use

☐ No

Section IV. Please complete for requests for hydrocodone ER (Hysingla ER), hydrocodone ER capsule, hydromorphone ER, levorphanol tablet, oxymorphone ER, and tapentadol ER.*

1. Has the member tried the following agents? ☐ Yes. Please describe below.

fentanyl transdermal Dose and frequency Dates of use Outcome

morphine ER Dose and frequency Dates of use Outcome

oxycodone ER Dose and frequency Dates of use Outcome

☐ No. If fentanyl transdermal, morphine ER, and oxycodone ER are contraindicated in this member, please describe.

2. For levorphanol tablet requests, please provide clinical rationale for the use of levorphanol instead of other long-acting opioids.

Section V. Please complete for hydromorphone suppository requests.*

Has the member tried morphine suppositories?

☐ Yes. Dose and frequency Dates of use Outcome

☐ No. If morphine suppositories are contraindicated in this member or there is medical necessity for the requested formulation, please describe.

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Section VI. Please complete for morphine ER capsule requests.*

1. Has the member tried morphine extended-release tablets?

   ☐ Yes. Dose and frequency _____ Dates of use _____ Outcome _____

   ☐ No. If morphine extended-release tablets are contraindicated in this member or there is medical necessity for the requested formulation, please describe. _____

2. Please provide medical necessity for once daily dosing. _____

Section VII. Please complete for meperidine (Demerol) requests.

Please attach documentation describing medical necessity due to allergy to morphine.

Section VIII. Please complete for requests for benzhydrocodone/acetaminophen, dihydrocodeine/acetaminophen/caffeine, hydrocodone 5 mg, 10 mg/ibuprofen, and oxycodone/acetaminophen 300mg.*

1. Please attach documentation of prior combination analgesic trials including hydrocodone/acetaminophen, oxycodone/acetaminophen, codeine/acetaminophen, and hydrocodone/ibuprofen.
2. For oxycodone/acetaminophen 300mg, please provide medical necessity for use instead of other opioid agents available in liquid formulations.

Section IX. Please complete for buprenorphine buccal film (Belbuca) requests.*

For requests for microdosing buprenorphine, please complete question 2.

1. Has the member tried a morphine extended-release product?

   ☐ Yes. Dose and frequency _____ Dates of use _____ Outcome _____

   ☐ No. If morphine is contraindicated in this member or there is medical necessity for the requested formulation, please describe.

2. Is the treatment plan to microdose buprenorphine with the intent to taper off full agonist opioid therapy?

   ☐ Yes ☐ No

   If yes, please document opioid taper plan, buprenorphine dosing, and tapering schedule. _____

Section X. Please complete for fentanyl transdermal 37.5, 62.5, 87.5 mcg/hr requests.*

Please provide medical necessity for use of requested formulation instead of other strengths. _____

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Section XI. Please complete for butorphanol nasal spray requests.

Please attach documentation describing an adverse reaction or contraindication to all other short-acting opioids, or medical necessity for nasal spray formulation in addition to an adverse reaction or contraindication to morphine and oxycodone IR solutions.

Section XII. Please complete for tramadol ER capsule (Conzip) and tramadol ER tablet requests.

1. Please provide medical necessity for use of an extended-release formulation.
2. Please attach documentation describing an inadequate response or adverse reaction to tramadol IR.

Section XIII. Please complete for Seglentis requests.

Please provide medical necessity for use of the combination product instead of the commercially available separate agents.

Section XIV. Please complete for tramadol 25 mg and 75 mg requests.

Please attach documentation describing an adverse reaction or contraindication to tramadol 50 mg tablet and tramadol/acetaminophen tablet.

Section XV. Please complete for tramadol 100 mg requests.

1. Please provide medical necessity for use of the requested strength.
2. Please attach documentation describing an inadequate response or adverse reaction to tramadol 50 mg at the requested dose.

Section XVI. Please complete for requests for codeine and tramadol products for members < 12 years of age.

Please provide clinical rationale for use of a codeine and tramadol-containing product in a member < 12 years of age.

Section XVII. Please complete for tramadol solution requests.*

Is there a medical necessity for use of an oral solution formulation?

☐ Yes. Please explain.

☐ No. Please attach medical records documenting inadequate response or adverse reaction to a tramadol immediate-release tablet formulation that is available without PA.

Section XVIII. Please complete for Roxybond (oxycodone immediate-release) requests.*

Please provide medical necessity for use of requested formulation instead of oxycodone immediate-release tablets available without prior authorization.

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Section XIX. Please complete for requests for duplicate short-acting or long-acting opioids.

Please provide clinical rationale for duplicate therapy including plan to consolidate therapy.

Section XX. Please complete for requests for Journavx above quantity limits (>29 units/60 days).

1. Is the diagnosis for a new acute episode of moderate to severe pain? ☐ Yes ☐ No
2. Please provide medical necessity for another 14-day course of therapy with the requested agent.

Section XXI. Please complete for requests above established dose limits.

For all opioids, please provide medical records documenting treatment plan including clinical rationale for high dose and titration of medication up to current dose. In addition, please provide a signed and dated patient-prescriber agreement and a consult from a pain specialist recommending the requested dose for this member. If a current pain consult is not available, please provide the anticipated date of upcoming pain consult. If there are plans to initiate a taper of the requested medication within the next 90 days, please provide medical records documenting treatment plan. For acetaminophen and aspirin products, please provide a clinical rationale for the use above 4 grams per day. For ibuprofen products, please provide a clinical rationale for the use above 3.2 grams per day.

Section XXII. Please complete for requests for high dose short-acting opioids as monotherapy.

Please provide medical records documenting treatment plan including clinical rationale for use of high dose short-acting opioids without a long-acting opioid agent. In addition, please provide clinical rationale for high dose and titration of medication up to current dose, a signed and dated patient-prescriber agreement, and a consult from a pain specialist recommending the requested dose for this member.

Section XXIII. Please complete for requests above established quantity limits (except Journavx).

Can the requested dose be obtained by using products within established quantity limits (i.e., for oxycodone ER 20 mg, 2 tablets twice daily could be consolidated to one oxycodone ER 40 mg tablet twice daily)?

☐ Yes ☐ No. If dose consolidation is not an option, please explain why.

Section XXIV. Please complete for concurrent therapy with opioid dependence agents.

1. Are you the prescriber of both buprenorphine/naloxone or buprenorphine and the opioid? ☐ Yes ☐ No
2. Prior to continuing buprenorphine/naloxone or buprenorphine therapy, will the member be discontinuing the opioid(s)? ☐ Yes ☐ No

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3. Please document the medical necessity for concurrent buprenorphine/naloxone or buprenorphine and opioid therapy. Please submit medical records supporting the medical necessity, including the specific pain that the current opioid is being used to treat.

4. Please document the complete treatment plan, including expected duration of therapy for this member in regard to acute pain management with concurrent buprenorphine/naloxone or buprenorphine and opioid therapy.

**Attach a letter with additional information regarding medication trials as applicable. If MassHealth pharmacy claims history of required trials is not available, medical records documenting such trials may be required.*

Section XXV. Concomitant Opioid and Benzodiazepine Polypharmacy. Please complete information for medications requested and clinical rationale for polypharmacy with opioids and benzodiazepines [≥ 15 days supply for one or more opioid(s) who are newly starting opioid therapy and one or more benzodiazepine(s), excluding clobazam, nasal and rectal diazepam, nasal midazolam, and injectable formulations for ≥ 15 days supply within a 45-day period].

Please document the indication or ICD-10 code(s), if applicable, for the agents requested.

1. Opioid

   Name/dose/frequency Indication

   Name/dose/frequency Indication

   Name/dose/frequency Indication

2. Benzodiazepine

   Name/dose/frequency Indication

   Name/dose/frequency Indication

   Name/dose/frequency Indication

Please document clinical rationale for concomitant use of opioids and benzodiazepines for this member.

Please describe the ongoing treatment plan for continued use.

Has the member had trials with three non-opioid therapies?

☐ Yes. Drug name Dates Outcome

Drug name Dates Outcome

Drug name Dates Outcome

Other Dates Outcome

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☐ No. Please document clinical rationale for the use of opioids instead of non-opioid alternatives.

Has consideration been given for possible taper of benzodiazepine or opioid?

☐ Yes. Please describe plan for taper and plan to reevaluate in the future.

☐ No. Please describe why taper is not possible at this time and plan to reevaluate in the future.

Has the member been offered and/or given a prescription for naloxone treatment?

☐ Yes ☐ No. Please provide details.

**Attach a letter with additional information regarding medication trials as applicable.*

Section XXVI. 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

Please continue to next page and complete Prescriber and Provider Information section.

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Prior Authorization Request Prescriber and Provider Information

Prescriber information

Last name* First name* MI

NPI* Individual MH Provider ID

DEA No. Office Contact Name

Address City State Zip

E-mail address

Telephone No.*

Fax No.* (Please provide fax number for PA response notification.)

** Required*

Please also complete for professionally administered medications, if applicable.

Start date End date

Servicing prescriber/facility name ☐ Same as prescribing provider

Servicing provider/facility address

Servicing provider NPI/tax ID No.

Name of billing provider

Billing provider NPI No.

Is this a request for recertification? ☐ Yes ☐ No

CPT code No. of visits J code No. of units

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

Date

(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.)