Print Clear

Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Topical Vitamin D Analogues 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.**

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Medication requested and tube size

☐ calcipotriene cream (quantity > 60 grams/month)
☐ 60 gram tube ☐ 120 gram tube

☐ calcipotriene foam
☐ 60 gram tube ☐ 120 gram tube

☐ calcipotriene ointment (quantity > 60 grams/month)
☐ 60 gram tube ☐ 120 gram tube

☐ calcitriol ointment
☐ 100 gram tube
☐ Other* _____

Frequency of application

_____

Indication (Check all that apply.)
☐ Plaque psoriasis
☐ Other (Please indicate.)
_____
_____
_____

** 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 requests for calcitriol ointment and calcipotriene foam.

1. Has the member had a trial with a topical corticosteroid?
   ☐ Yes. Please list the drug name, dates/duration of use, and outcome of trial as noted below.*
   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following outcomes? ☐ Adverse reaction ☐ Inadequate response
   Briefly describe details of adverse reaction or inadequate response. _____
   _____
   ☐ No. Does the member have a contraindication to topical corticosteroids? Please explain.
   _____
   _____

2. Has the member had a trial with calcipotriene cream, ointment, or scalp solution?
   ☐ Yes. Please list the drug name, dates/duration of use, and outcome of trial as noted below.*
   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following outcomes? ☐ Adverse reaction ☐ Inadequate response
   Briefly describe details of adverse reaction or inadequate response. _____
   _____
   ☐ No. Does the member have a contraindication to calcipotriene cream, ointment, and scalp solution?
   Please explain.
   _____
   _____

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

Section II. Please complete for requests for quantities exceeding established quantity limits.

Please describe the clinical rationale for exceeding the quantity limit.

_____
_____

Section III. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

_____
_____

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.* _____
* *Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my 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.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required_____

Printed name of prescribing provider _____ Date _____