



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

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.

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

- | | |
|---|--|
| <input type="checkbox"/> Cambia (diclofenac powder for solution) | <input type="checkbox"/> meloxicam capsule |
| <input type="checkbox"/> diclofenac/misoprostol < 60 years of age | <input type="checkbox"/> meloxicam suspension |
| <input type="checkbox"/> diclofenac topical patch [Flector] | <input type="checkbox"/> naproxen controlled-release |
| <input type="checkbox"/> etodolac extended-release | <input type="checkbox"/> naproxen suspension < 13 years of age |
| <input type="checkbox"/> fenoprofen | <input type="checkbox"/> naproxen/esomeprazole < 60 years of age |
| <input type="checkbox"/> ibuprofen/famotidine < 60 years of age | <input type="checkbox"/> Qmiiiz (meloxicam orally disintegrating tablet) |
| <input type="checkbox"/> Indocin (indomethacin suspension) | <input type="checkbox"/> Relafen DS (nabumetone 1000 mg) |
| <input type="checkbox"/> ketoprofen extended-release | <input type="checkbox"/> salsalate |
| <input type="checkbox"/> ketorolac > 20 units/month | <input type="checkbox"/> tolmetin |
| <input type="checkbox"/> ketorolac nasal spray | <input type="checkbox"/> Zipsor (diclofenac 25 mg capsule) |
| <input type="checkbox"/> Licart (diclofenac topical patch) | <input type="checkbox"/> Zorvolex (diclofenac 18 mg, 35 mg capsule) |
| <input type="checkbox"/> meclofenamate | <input type="checkbox"/> Other* _____ |

Dose, frequency, and duration of medication requested _____

Indication _____

** 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 IV.
 No. Please indicate why not. _____
- For Licart requests, has the member tried diclofenac topical patch?
 Yes. Please complete Section IV.
 No. Please indicate why not. _____

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

1. Please provide clinical rationale for the use of the requested formulation instead of other available immediate-release products or solid dosage formulations.

2. For solution products and suspension products, has the member tried ibuprofen suspension?

Yes. Please complete Section IV.

No. Please indicate why not. _____

3. For Cambia, has the member tried naproxen suspension?

Yes. Please complete Section IV.

No. Please indicate why not. _____

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

Please attach medical records/office notes documenting medical necessity. 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 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.

Section V. Please complete for ketorolac requests exceeding the quantity limit.

Please describe the medical necessity for exceeding the quantity limit.

Section VI. 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 _____