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

Print Clear

Benign Prostatic Hyperplasia (BPH) Agents 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

BPH medication requested

☐ dutasteride/tamsulosin ☐ silodosin ☐ tadalafil 5 mg

Indication (Check all that apply.)

☐ BPH
☐ Enlarged prostate
☐ Lower urinary tract symptoms
☐ S/P transurethral resection of the prostate (TURP)
☐ Other _____

Please note: MassHealth does not pay for any drug when used for the treatment of male or female sexual dysfunction, cosmetic purposes, or for hair growth as described in 130 CMR 406.413(B): Drug Exclusions. For additional information go to: www.mass.gov/regulations/130-CMR-406000-pharmacy-services.

Dose, frequency, and duration of medication requested _____

Section I. Please complete for silodosin requests.

Has the member had a trial with alfuzosin and tamsulosin?

☐ Yes. Please list the drug names, dates/duration of trials, and outcomes below.*

Drug name _____ Dates/duration of use _____
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

_____

Drug name _____ Dates/duration of use _____
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

_____

☐ No. Please provide clinical rationale for not using alfuzosin and tamsulosin.

_____

Section II. Please complete for dutasteride/tamsulosin requests.

1. Has the member had a trial with an alpha-1 blocker (alfuzosin, doxazosin, tamsulosin, or terazosin)?
   ☐ Yes. Please list the drug name, dates/duration of trials, and outcomes below.*
   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, contraindication, or other.
   _____
   ☐ No. Please provide clinical rationale for not using an alpha-1 blocker.
   _____
2. Has the member had a trial with finasteride?
   ☐ Yes. Please list the dates/duration of trials and outcomes.*
   Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, contraindication, or other.
   _____
   ☐ No. Please provide clinical rationale for not using finasteride.
   _____
3. Please provide medical necessity for use of the combination product instead of the commercially available separate agents.
   _____
   _____

Section III. Please complete for tadalafil 5 mg requests.

Please attach medical records documenting an inadequate response, adverse reaction, or contraindication to tamsulosin, alfuzosin, silodosin, and a 5 alpha-reductase inhibitor (i.e., dutasteride, finasteride). In addition, attach medical records documenting an inadequate response, adverse reaction, or contraindication to combination therapy with an alpha-1 blocker and a 5 alpha-reductase inhibitor.

Section IV. 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*

over

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 _____