



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](http://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"/> ketorolac nasal spray                      |
| <input type="checkbox"/> diclofenac 25 mg capsule                 | <input type="checkbox"/> Licart (diclofenac topical patch)          |
| <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 topical patch [Flector]       | <input type="checkbox"/> naproxen controlled-release                |
| <input type="checkbox"/> Elyxyb (celecoxib oral solution)         | <input type="checkbox"/> naproxen suspension < 13 years of age      |
| <input type="checkbox"/> etodolac extended-release                | <input type="checkbox"/> naproxen/esomeprazole < 60 years of age    |
| <input type="checkbox"/> fenoprofen                               | <input type="checkbox"/> Relafen DS (nabumetone 1000 mg)            |
| <input type="checkbox"/> ibuprofen/famotidine < 60 years of age   | <input type="checkbox"/> salsalate                                  |
| <input type="checkbox"/> Indocin (indomethacin suspension)        | <input type="checkbox"/> tolmetin                                   |
| <input type="checkbox"/> ketoprofen extended-release              | <input type="checkbox"/> Zorvolex (diclofenac 18 mg, 35 mg capsule) |
| <input type="checkbox"/> ketorolac > 20 units/month               | <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 (generic Flector)?  
 Yes. Please complete Section IV.  
 No. Please indicate why not. \_\_\_\_\_

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

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

\_\_\_\_\_

\_\_\_\_\_

2. For Indocin and naproxen 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. \_\_\_\_\_

4. For Elyxyb, has the member tried celecoxib capsules?

Yes. Please complete Section IV.

No. Please indicate why not. \_\_\_\_\_

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**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.

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**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.

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

Please describe the medical necessity for exceeding the quantity limit.

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\_\_\_\_\_

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**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.

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**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*

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**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 \_\_\_\_\_