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

Topical Corticosteroids
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

Class I Superpotent products (See Sections I., II., and III.)

- ☐ clobetasol propionate (Clobex, Impeklo, Olux-E): gel, lotion, shampoo, shampoo-kit,
- ☐ diflorasone: ointment
- ☐ halobetasol: foam
- ☐ halobetasol (Bryhali, Ultravate): lotion

Class II Potent products (See Sections I., II., and III.)

- ☐ betamethasone dipropionate (Sernivo): spray
- ☐ desoximetasone (Topicort): ointment, spray (0.25%), gel (0.05%)
- ☐ diflorasone (Apexicon-E): cream
- ☐ halcinonide (Halog): cream, solution

Class III Upper Mid-Strength Potent products (See Sections I., II., and III.)

- ☐ amcinonide: cream, lotion
- ☐ desoximetasone (Topicort): cream, ointment
- ☐ diflorasone: cream

Class IV Mid-Strength Potent products (See Sections I., II., and III.)

- ☐ clocortolone (Cloderm): cream
- ☐ fluocinolone (Synalar): ointment-kit
- ☐ flurandrenolide: ointment
- ☐ hydrocortisone valerate: ointment
- ☐ triamcinolone: ointment (0.05%), spray

Class V Lower Mid-Strength Potent products (See Sections I., II., and III.)

- ☐ desonide: lotion
- ☐ fluocinolone (Synalar): cream-kit
- ☐ flurandrenolide: cream, lotion
- ☐ fluticasone propionate (Cutivate): lotion
- ☐ hydrocortisone butyrate: lotion
- ☐ hydrocortisone butyrate/emollient: cream

Class VI Mild Potent products (See Sections I., II., and III.)

- ☐ desonide (Desonate): gel
- ☐ fluocinolone (Synalar): solution-kit

Class VII Least Potent products (See Sections I., II., and III.)

☐ hydrocortisone: solution

Combination products

☐ betamethasone/calcipotriene (Enstilar, Taclonex): foam, ointment, scalp suspension

☐ halobetasol/tazarotene (Duobrii): lotion

☐ neomycin/fluocinolone: cream, cream-kit

Strength and formulation requested ____________________

Frequency and duration of therapy ____________________ **Drug NDC (if known)** ____________________

Diagnosis and/or indication ____________________

Section I. Please complete for all requests, excluding combination products.

Has the member had a trial with all topical corticosteroids of the same formulation and potency range that are available without prior authorization?

☐ Yes. Please list the specific drug name, dates/duration of use, and outcomes below*.

Drug name, strength, and formulation ____________________ 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.

____

Drug name, strength, and formulation ____________________ 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.

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Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response

Briefly describe details of adverse reaction or inadequate response.

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Drug name, strength, and formulation ____________________ 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.

____

Drug name, strength, and formulation ____________________ 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.

____

☐ No. Please explain contraindication or clinical rationale for not using other topical corticosteroid(s) that are available without prior authorization in this member.

____

Section II. Please complete for foam and shampoo formulations in scalp-related conditions.

Has the member had a trial with one topical corticosteroid of a similar formulation and similar or greater potency range that is available without prior authorization?

☐ Yes. Please list the specific drug name, dates/duration of use, and outcomes below*.

Drug name, strength, and formulation ____________________ 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.

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☐ No. Please explain contraindication or clinical rationale for not using other topical corticosteroid(s) that are available without prior authorization for this member.

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Section III. Please complete for Impeklo requests.

Please attach medical records documenting an inadequate response or adverse reaction to clobetasol propionate lotion (generic Clobex).

Section IV. Please complete for foam, gel, kit, shampoo, solution, and spray formulations.

Explain medical necessity for the requested formulation. _____

_____

Section V. Please complete for combination products.

1. Provide compelling clinical rationale for why the combination product would offer a therapeutic advantage over the individual agents. _____

   _____

2. For Duobrii, has the member had a trial with one superpotent or potent topical corticosteroid?

   ☐ Yes. Please list the specific drug name, dates/duration of use, and outcomes below.* Drug name, strength, and formulation _____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.

   _____

   ☐ No

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

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 _____