



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

## Opioids/Acetaminophen Analgesic 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 opioid and acetaminophen analgesic 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

**Drug name** \_\_\_\_\_ **Dose and frequency** \_\_\_\_\_ **Duration of therapy** \_\_\_\_\_  
**Indication** \_\_\_\_\_

Has the prescriber evaluated Massachusetts Prescription Awareness Tool (MassPAT) data, risk factors, and potential risk factors for abuse/misuse in their assessment of this member?  Yes  No

For mid-level practitioners (e.g., nurse practitioners, physician assistants), please provide the name and specialty of the collaborating physician. \_\_\_\_\_

Is this member a referral candidate for care coordination?  Yes  No

If yes, MassHealth will offer care coordination services to this member. Please describe which additional behavioral health service would be beneficial.  
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### Section I. Please complete for oxycodone extended-release (ER) tablet (Oxycontin) requests.\*

Has the member tried a long-acting morphine product or a fentanyl transdermal product?

- Yes. Drug \_\_\_\_\_ Dose and frequency \_\_\_\_\_ Dates of use \_\_\_\_\_ Outcome \_\_\_\_\_  
 No. If morphine and fentanyl transdermal are contraindicated in this member, please describe. \_\_\_\_\_  
 \_\_\_\_\_

### Section II. Please complete for methadone (Dolophine, Methadose) requests.\*

1. Has the member tried a long-acting morphine product?

- Yes. Dose and frequency \_\_\_\_\_ Dates of use \_\_\_\_\_ Outcome \_\_\_\_\_  
 No. If morphine is contraindicated in this member, please describe. \_\_\_\_\_  
 \_\_\_\_\_

2. Has the member tried a fentanyl transdermal product?

- Yes. Dose and frequency \_\_\_\_\_ Dates of use \_\_\_\_\_ Outcome \_\_\_\_\_

No. If fentanyl transdermal is contraindicated in this member, please describe. \_\_\_\_\_

3. If the answer to questions 1 and 2 is no, please provide clinical rationale for the use of methadone instead of other long-acting opioids. \_\_\_\_\_
4. Is the member opioid naive?  Yes  No
5. Has the member had a baseline ECG showing a normal QTc interval?  Yes  No

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**Section III. Please complete for requests for fentanyl transmucosal system (Actiq), fentanyl buccal tablet (Fentora), oxymorphone immediate-release (IR), and tapentadol (Nucynta).\***

1. Is the member currently maintained on a long-acting opioid regimen?  
 Yes. Drug \_\_\_\_\_ Dose and frequency \_\_\_\_\_ Dates of use \_\_\_\_\_  
 No
2. Has the member tried the following agents?  Yes. Please describe below.  
hydromorphone IR      Dose and frequency \_\_\_\_\_ Dates of use \_\_\_\_\_ Outcome \_\_\_\_\_  
morphine IR              Dose and frequency \_\_\_\_\_ Dates of use \_\_\_\_\_ Outcome \_\_\_\_\_  
oxycodone IR            Dose and frequency \_\_\_\_\_ Dates of use \_\_\_\_\_ Outcome \_\_\_\_\_  
 No. If hydromorphone, morphine, and oxycodone are contraindicated in this member, please describe. \_\_\_\_\_
3. If the request is for fentanyl buccal tablet, has the member tried fentanyl transmucosal system (Actiq)?  
 Yes. Dose and frequency \_\_\_\_\_ Dates of use \_\_\_\_\_ Outcome \_\_\_\_\_  
 No. If fentanyl transmucosal system (Actiq) is contraindicated in this member, please describe. \_\_\_\_\_

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**Section IV. Please complete for requests for hydrocodone ER (Hysingla ER, Zohydro ER), hydromorphone ER, levorphanol tablet, oxycodone ER capsule (Xtampza), oxymorphone ER, and tapentadol ER (Nucynta ER).\***

1. Has the member tried the following agents?  Yes. Please describe below.  
fentanyl transdermal      Dose and frequency \_\_\_\_\_ Dates of use \_\_\_\_\_ Outcome \_\_\_\_\_  
morphine ER                Dose and frequency \_\_\_\_\_ Dates of use \_\_\_\_\_ Outcome \_\_\_\_\_  
oxycodone ER              Dose and frequency \_\_\_\_\_ Dates of use \_\_\_\_\_ Outcome \_\_\_\_\_  
 No. If fentanyl transdermal, morphine ER, and oxycodone ER are contraindicated in this member, please describe. \_\_\_\_\_
2. If the request is for levorphanol tablet, please provide clinical rationale for the use of levorphanol instead of other long-acting opioids. \_\_\_\_\_

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**Section V. Please complete for morphine ER capsule requests.\***

1. Has the member tried morphine extended-release tablets?  
 Yes. Dose and frequency \_\_\_\_\_ Dates of use \_\_\_\_\_ Outcome \_\_\_\_\_  
 No. If morphine extended-release tablets are contraindicated in this member or there is clinical rationale for the requested formulation, please describe. \_\_\_\_\_
2. Please provide medical necessity for once daily dosing. \_\_\_\_\_

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**Section VI. Please complete for meperidine (Demerol) requests.**

Please attach documentation describing medical necessity due to allergy to morphine.

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**Section VII. Please complete for requests for benzhydrocodone/acetaminophen, dihydrocodeine/acetaminophen/caffeine, hydrocodone/acetaminophen 300mg, hydrocodone 5 mg, 10 mg/ibuprofen, and oxycodone/acetaminophen 300mg.\***

Please attach documentation of prior generic combination analgesic trials including hydrocodone/acetaminophen, oxycodone/acetaminophen, codeine/acetaminophen, and hydrocodone/ibuprofen.

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**Section VIII. Please complete for buprenorphine buccal film (Belbuca) requests.\***

Has the member tried a long-acting morphine product?

- Yes. Dose and frequency \_\_\_\_\_ Dates of use \_\_\_\_\_ Outcome \_\_\_\_\_
- No. If morphine is contraindicated in this member or there is clinical rationale for the requested formulation, please describe. \_\_\_\_\_
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**Section IX. Please complete for fentanyl transdermal 37.5, 62.5, 87.5 mcg/hr requests.\***

Please provide clinical rationale for use of requested formulation over other strengths. \_\_\_\_\_

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**Section X. Please complete for butorphanol nasal spray requests.**

Please attach documentation describing an adverse reaction or contraindication to all other short-acting opioids, or medical necessity for nasal spray formulation in addition to an adverse reaction or contraindication to morphine and oxycodone IR solutions.

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**Section XI. Please complete for tramadol ER (Conzip and generics) requests.**

1. Please provide clinical rationale for use of an extended-release formulation. \_\_\_\_\_
  2. Please attach documentation describing an inadequate response or adverse reaction to tramadol IR.
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**Section XII. Please complete for Seglentis and tramadol/acetaminophen (Ultracet) requests.**

Please provide medical necessity for use of the combination product instead of the separately available ingredients.

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**Section XIII. Please complete for tramadol 100 mg requests.**

1. Please provide medical necessity for use of the requested strength. \_\_\_\_\_
  2. Please attach documentation describing an inadequate response or adverse reaction to tramadol 50 mg at the requested dose.
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**Section XIV. Please complete for requests for codeine and tramadol products for members < 12 years old.**

Please provide clinical rationale for use of a codeine and tramadol-containing product in a member < 12 years old.

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**Section XV. Please complete for oxycodone IR (Oxaydo) requests.\***

Please provide clinical rationale for use instead of oxycodone IR 5 mg scored tablets. \_\_\_\_\_  
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**Section XVI. Please complete for oliceridine (Olinvyk<sup>^</sup>) requests.\***

1. Is the total course of therapy limited to 48 hours?  Yes  No
2. Has the member tried the following agents?  Yes. Please describe below.  
fentanyl injection            Dose and frequency \_\_\_\_\_ Dates of use \_\_\_\_\_ Outcome \_\_\_\_\_  
hydromorphone injection    Dose and frequency \_\_\_\_\_ Dates of use \_\_\_\_\_ Outcome \_\_\_\_\_  
morphine injection            Dose and frequency \_\_\_\_\_ Dates of use \_\_\_\_\_ Outcome \_\_\_\_\_  
 No. If fentanyl injection, hydromorphone injection, and morphine injection are contraindicated in this member, please describe.

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*<sup>^</sup> This drug is available through the health care professional who administers the drug. MassHealth does not pay for this drug to be dispensed through a retail pharmacy.*

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**Section XVII. Please complete for requests for duplicate short-acting or long-acting opioids.**

Please provide clinical rationale for duplicate therapy including plan to consolidate therapy.

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**Section XVIII. Please complete for requests above established dose limits.**

For all opioids, please provide medical records documenting treatment plan including clinical rationale for high dose and titration of medication up to current dose. In addition, please provide a signed and dated patient-prescriber agreement and a consult from a pain specialist recommending the requested dose for this member. For acetaminophen and aspirin products, please provide a clinical rationale for the use above 4 grams per day. For ibuprofen products, please provide a clinical rationale for the use above 3.2 grams per day.

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**Section XIX. Please complete for requests for high dose short-acting opioids as monotherapy.**

Please provide medical records documenting treatment plan including clinical rationale for use of high dose short-acting opioids without a long-acting opioid agent. In addition, please provide clinical rationale for high dose and titration of medication up to current dose, a signed and dated patient-prescriber agreement, and a consult from a pain specialist recommending the requested dose for this member.

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**Section XX. Please complete for requests above established quantity limits.**

Can the requested dose be obtained by using products within established quantity limits (i.e., for oxycodone ER 20 mg, 2 tablets twice daily could be consolidated to one oxycodone ER 40 mg tablet twice daily)?  
 Yes  No. If dose consolidation is not an option, please explain why. \_\_\_\_\_

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**Section XXI. Please complete for concurrent therapy with opioid dependence agents.**

1. Are you the prescriber of both buprenorphine/naloxone or buprenorphine and the opioid?  Yes  No
  2. Prior to continuing buprenorphine/naloxone or buprenorphine therapy, will the member be discontinuing the opioid(s)?  Yes  No
  3. Please document the medical necessity for concurrent buprenorphine/naloxone or buprenorphine and opioid therapy. Please submit medical records supporting the medical necessity, including the specific pain that the current opioid is being used to treat.
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4. Please document the complete treatment plan, including expected duration of therapy for this member in regard to acute pain management with concurrent buprenorphine/naloxone or buprenorphine and opioid therapy.

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**Section XXII. 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. If MassHealth pharmacy claims history of required trials is not available, medical records documenting such trials may be required.*

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