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

Headache Therapy (Butalbital Combination 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

Medication requested

- ☐ butalbital/acetaminophen (25 mg/325 mg)
- ☐ butalbital/acetaminophen (50 mg/300 mg)
- ☐ butalbital/acetaminophen (50 mg/325 mg)
- ☐ butalbital/acetaminophen/caffeine (50 mg/ 300 mg/40 mg)
- ☐ butalbital/acetaminophen/caffeine capsule (50 mg/325 mg/40 mg)
- ☐ butalbital/acetaminophen/caffeine tablet (50 mg/325 mg/40 mg) > 20 units/month, < 18 years of age
- ☐ butalbital/acetaminophen/caffeine solution
- ☐ butalbital/acetaminophen/caffeine/codeine (50 mg/300 mg/40 mg/30 mg)
- ☐ butalbital/acetaminophen/caffeine/codeine (50 mg/325 mg/40 mg/30 mg) > 20 units/month, < 18 years of age
- ☐ butalbital/aspirin/caffeine capsule (50 mg/325 mg/40 mg)
- ☐ butalbital/aspirin/caffeine tablet (50 mg/325 mg/40 mg) > 20 units/month, < 18 years of age
- ☐ butalbital/aspirin/caffeine/codeine (50 mg/325 mg/40 mg/30 mg)
- ☐ Other butalbital agent _____

Quantity requested per month _____

Dose, frequency, and duration of medication requested _____

Indication (Check all that apply.)

- ☐ Cluster headache. Frequency of headaches (number/month) _____
- ☐ Migraine headache. Frequency of migraine attacks (number/month) _____
- ☐ Tension headache. Frequency of headaches (number/month) _____
- ☐ Other. Specify pertinent medical history, diagnostic studies, and/or laboratory tests. _____

_____

Section I. Please complete for butalbital agent requests exceeding quantity limits or for members < 18 years of age.

1. For migraine headache requests, has the member tried two triptans?
   ☐ Yes. Please list the drug names and outcomes below.

Drug name ______________________________ ☐ Adverse reaction ☐ Inadequate response
Briefly describe the details of adverse reaction or inadequate response.
____

Drug name ______________________________ ☐ Adverse reaction ☐ Inadequate response
Briefly describe the details of adverse reaction or inadequate response.
____

☐ No. Explain why triptans are not appropriate in this member.
____

2. For migraine headache requests, has the member tried an oral calcitonin gene-related peptide (CGRP) inhibitor?
   ☐ Yes. Please list the drug name and outcome below.
   Drug name ______________________________ ☐ Adverse reaction ☐ Inadequate response
   Briefly describe the details of adverse reaction or inadequate response.
   ____
   ☐ No. Explain why oral CGRP inhibitors are not appropriate in this member.
   ____
3. For both migraine and tension headache requests, is the member currently receiving prophylaxis?
   ☐ Yes. Please specify.
   Drug name _________________________ Dose and frequency _______________________
   Drug name _________________________ Dose and frequency _______________________
   ☐ No. Explain why prophylaxis is not appropriate in this member.
   ____
4. Is the member under the care of a neurologist? ☐ Yes ☐ No
5. Please list any other prior headache therapy trials. Please list the drug names and outcomes below.
   Drug name ___________________________ ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   ____
   Drug name ___________________________ ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   ____
   Drug name ___________________________ ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   ____
   Drug name ___________________________ ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   ____
   Drug name ___________________________ ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   ____

Section II. Please also complete for requests for butalbital/aspirin/caffeine capsule and butalbital 50 mg/acetaminophen 325 mg/caffeine 40 mg capsule.

Has the member tried butalbital 50 mg/acetaminophen 325 mg/caffeine 40 mg tablet?

☐ Yes. Please list the dates/duration of use and outcome below.
Dates/duration of use ____________________ ☐ Adverse reaction ☐ Inadequate response ☐ Other
Briefly describe details of adverse reaction, inadequate response, or other.
____

over

☐ No. Explain why butalbital 50 mg/acetaminophen 325 mg/caffeine 40 mg tablet is not appropriate in this member.

_____

Section III. Please also complete for requests for all other butalbital agents that require PA and requests for codeine-containing products for members < 12 years of age.

Please provide clinical rationale for the requested agent. Please address the need for the requested agent instead of formulations available without PA, requested dosage formulation instead of conventional dosage forms, or use in the requested age group as appropriate.

_____

_____

_____

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 _____