



Prior Authorization Request Administrative Information

Member information

Last name First name MI

Member ID Date of birth

Sex assigned at birth Female Male "X" or Intersex

Current gender Female Male Transgender male Transgender female Other

Place of residence Home Nursing facility Other

Race Ethnicity

Preferred spoken language Preferred written language

MassHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, creed, sexual orientation, or sex (including gender identity and gender stereotyping).

Plan contact information

Please indicate the member's MassHealth Plan and fax or submit this completed and signed form according to the Plan's contact information below.

<p>MassHealth Fee-For-Service (FFS) Plan, Primary Care Clinician (PCC) Plan, Primary Care Accountable Care Organization (PCACO) Plan, Children's Medical Security Plan, and Health Safety Net Plan</p> <p><input type="checkbox"/> MassHealth Drug Utilization Review Program Pharmacy: Fax: (877) 208-7428 - Tel: (800) 745-7318</p>
<p>MassHealth Managed Care Organization (MCO) and Accountable Care Partnership Plans (ACPP)</p> <p><input type="checkbox"/> Fallon Health Online Prior Authorization: go.covermy meds.com/OptumRx Online Prior Authorization: providerportal.surescripts.net/ProviderPortal/optum Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033</p>
<p><input type="checkbox"/> Health New England Online Prior Authorization: go.covermy meds.com/OptumRx Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545</p>
<p><input type="checkbox"/> Mass General Brigham Health Plan Online Prior Authorization (Non-Specialty Drugs): go.covermy meds.com/OptumRx Online Prior Authorization (Specialty/Medical Drugs): provider.massgeneralbrighamhealthplan.org Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555</p>
<p><input type="checkbox"/> Tufts Health Plan Online Prior Authorization: point32health.promptpa.com Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985</p>
<p><input type="checkbox"/> WellSense Health Plan Online Prior Authorization: wellsense.org/providers/ma/pharmacy/prior-authorizations Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822</p>

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.

Medication information

Drug name Dose and frequency Duration of therapy

Indication or ICD-10 code, if applicable

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

Has the member been offered and/or given a prescription for naloxone treatment?

Yes No. Please provide details.

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. *Please inform the member, parent, or legal guardian to expect outreach from a MassHealth representative of care coordination services.*

Section I. Please complete for oxycodone extended-release (ER) tablet (Oxycontin) requests.*

Has the member tried a morphine extended-release 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 (Methadose) requests.*

1. Has the member tried a morphine extended-release 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

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

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 | <input type="text"/> | Dates of use | <input type="text"/> | Outcome | <input type="text"/> |
| morphine IR | Dose and frequency | <input type="text"/> | Dates of use | <input type="text"/> | Outcome | <input type="text"/> |
| oxycodone IR | Dose and frequency | <input type="text"/> | Dates of use | <input type="text"/> | Outcome | <input type="text"/> |
- 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?
- Yes. Dose and frequency Dates of use Outcome
- No. If fentanyl transmucosal system is contraindicated in this member, please describe.

Section IV. Please complete for requests for hydrocodone ER (Hysingla ER), hydrocodone ER capsule, hydromorphone ER, levorphanol tablet, and oxymorphone ER.*

1. Has the member tried the following agents? Yes. Please describe below.
- | | | | | | | |
|----------------------|--------------------|----------------------|--------------|----------------------|---------|----------------------|
| fentanyl transdermal | Dose and frequency | <input type="text"/> | Dates of use | <input type="text"/> | Outcome | <input type="text"/> |
| morphine ER | Dose and frequency | <input type="text"/> | Dates of use | <input type="text"/> | Outcome | <input type="text"/> |
| oxycodone ER | Dose and frequency | <input type="text"/> | Dates of use | <input type="text"/> | Outcome | <input type="text"/> |
- No. If fentanyl transdermal, morphine ER, and oxycodone ER are contraindicated in this member, please describe.
2. For levorphanol tablet requests, please provide clinical rationale for the use of levorphanol instead of other long-acting opioids.

Section V. Please complete for hydromorphone suppository requests.*

- Has the member tried morphine suppositories?
- Yes. Dose and frequency Dates of use Outcome
- No. If morphine suppositories are contraindicated in this member or there is medical necessity for the requested formulation, please describe.

Section VI. 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 medical necessity for the requested formulation, please describe.

2. Please provide medical necessity for once daily dosing.

Section VII. Please complete for meperidine (Demerol) requests.

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

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

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

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

Has the member tried a morphine extended-release product?

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

Please provide medical necessity for use of requested formulation instead of other strengths.

Section XI. 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.

Section XII. Please complete for tramadol ER capsule (Conzip) and tramadol ER tablet requests.

1. Please provide medical necessity for use of an extended-release formulation.

2. Please attach documentation describing an inadequate response or adverse reaction to tramadol IR.

Section XIII. Please complete for Seglentis requests.

Please provide medical necessity for use of the combination product instead of the commercially available separate agents.

Section XIV. Please complete for tramadol 25 mg requests.

Please attach documentation describing an adverse reaction or contraindication to tramadol 50 mg tablet and tramadol/acetaminophen tablet.

Section XV. 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.

Section XVI. Please complete for requests for codeine and tramadol products for members < 12 years of age.

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

Section XVII. Please complete for tramadol solution requests.*

Is there a medical necessity for use of an oral solution formulation?

- Yes. Please explain.

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- No. Please attach medical records documenting inadequate response or adverse reaction to a tramadol immediate-release tablet formulation that is available without PA.

Section XVIII. Please complete for Roxybond (oxycodone immediate-release) requests.*

Please provide medical necessity for use of requested formulation instead of oxycodone immediate-release tablets available without prior authorization.

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Section XIX. Please complete for oliceridine (Olinvyk)^{MB} 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	<table border="1"><tr><td> </td></tr></table>		Dates of use	<table border="1"><tr><td> </td></tr></table>		Outcome	<table border="1"><tr><td> </td></tr></table>	
hydromorphone injection	Dose and frequency	<table border="1"><tr><td> </td></tr></table>		Dates of use	<table border="1"><tr><td> </td></tr></table>		Outcome	<table border="1"><tr><td> </td></tr></table>	
morphine injection	Dose and frequency	<table border="1"><tr><td> </td></tr></table>		Dates of use	<table border="1"><tr><td> </td></tr></table>		Outcome	<table border="1"><tr><td> </td></tr></table>	

No. If fentanyl injection, hydromorphone injection, and morphine injection are contraindicated in this member, please describe.

3. Please indicate billing preference. Prescriber in-office Hospital outpatient

If applicable, please also complete section for professionally administered medications at end of form.

^{MB} This drug is available through the health care professional who administers the drug or in an outpatient or inpatient hospital setting. MassHealth does not pay for this drug to be dispensed through the retail pharmacy. If listed, PA does not apply through the hospital outpatient and inpatient settings. Please refer to 130 CMR 433.408 for PA requirements for other health care professionals. Notwithstanding the above, this drug may be an exception to the unified pharmacy policy; please refer to respective MassHealth Accountable Care Partnership Plans (ACPPs) and Managed Care Organizations (MCOs) for PA status and criteria, if applicable.

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

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

Section XXI. 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. If a current pain consult is not available, please provide the anticipated date of upcoming pain consult. If there are plans to initiate a taper of the requested medication within the next 90 days, please provide medical records documenting treatment plan. 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.

Section XXII. 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.

Section XXIII. 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.

Section XXIV. 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

- Prior to continuing buprenorphine/naloxone or buprenorphine therapy, will the member be discontinuing the opioid(s)? Yes No
- 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.

- 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.

**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.*

Section XXV. Concomitant Opioid and Benzodiazepine Polypharmacy. Please complete information for medications requested and clinical rationale for polypharmacy with opioids and benzodiazepines [≥ 15 days supply for one or more opioid(s) who are newly starting opioid therapy and one or more benzodiazepine(s), excluding clobazam, nasal and rectal diazepam, nasal midazolam, and injectable formulations for ≥ 15 days supply within a 45-day period].

Please document the indication or ICD-10 code(s), if applicable, for the agents requested.

1. Opioid

Name/dose/frequency	<input type="text"/>	Indication	<input type="text"/>
Name/dose/frequency	<input type="text"/>	Indication	<input type="text"/>
Name/dose/frequency	<input type="text"/>	Indication	<input type="text"/>

2. Benzodiazepine

Name/dose/frequency	<input type="text"/>	Indication	<input type="text"/>
Name/dose/frequency	<input type="text"/>	Indication	<input type="text"/>
Name/dose/frequency	<input type="text"/>	Indication	<input type="text"/>

Please document clinical rationale for concomitant use of opioids and benzodiazepines for this member.

Please describe the ongoing treatment plan for continued use.

Has the member had trials with three non-opioid therapies?

<input type="checkbox"/> Yes. Drug name	<input type="text"/>	Dates	<input type="text"/>	Outcome	<input type="text"/>
Drug name	<input type="text"/>	Dates	<input type="text"/>	Outcome	<input type="text"/>
Drug name	<input type="text"/>	Dates	<input type="text"/>	Outcome	<input type="text"/>
Other	<input type="text"/>	Dates	<input type="text"/>	Outcome	<input type="text"/>

No. Please document clinical rationale for the use of opioids instead of non-opioid alternatives.

Has consideration been given for possible taper of benzodiazepine or opioid?

Yes. Please describe plan for taper and plan to reevaluate in the future.

No. Please describe why taper is not possible at this time and plan to reevaluate in the future.

Has the member been offered and/or given a prescription for naloxone treatment?

Yes No. Please provide details.

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

Section XXVI. Please complete and provide documentation for exceptions to step therapy.

1. Is the alternative drug required under the step therapy protocol contraindicated, or will likely cause an adverse reaction in, or physical or mental harm to, the member? Yes No

If yes, briefly describe details of contraindication, adverse reaction, or harm.

2. Is the alternative drug required under the step therapy protocol expected to be ineffective based on the known clinical characteristics of the member and the known characteristics of the alternative drug regimen?

Yes No

If yes, briefly describe details of known clinical characteristics of member and alternative drug regimen.

3. Has the member previously tried the alternative drug required under the step therapy protocol, or another alternative drug in the same pharmacologic class or with the same mechanism of action, and such alternative drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?

Yes No

If yes, please provide details for the previous trial.

Drug name

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.

4. Is the member stable on the requested prescription drug prescribed by the health care provider, and switching drugs will likely cause an adverse reaction in, or physical or mental harm to, the member?

Yes. Please provide details.

No

Please continue to next page and complete Prescriber and Provider Information section.

Prior Authorization Request Prescriber and Provider Information

Prescriber information

Last name*	<input type="text"/>	First name*	<input type="text"/>	MI	<input type="text"/>
NPI*	<input type="text"/>	Individual MH Provider ID	<input type="text"/>		
DEA No.	<input type="text"/>	Office Contact Name	<input type="text"/>		
Address	<input type="text"/>	City	<input type="text"/>	State	<input type="text"/>
		Zip	<input type="text"/>		
E-mail address	<input type="text"/>				
Telephone No.*	<input type="text"/>				
Fax No.* (Please provide fax number for PA response notification.)	<input type="text"/>				

* Required

Please also complete for professionally administered medications, if applicable.

Start date	<input type="text"/>	End date	<input type="text"/>		
Servicing prescriber/facility name	<input type="text"/>	<input type="checkbox"/>	Same as prescribing provider		
Servicing provider/facility address	<input type="text"/>				
Servicing provider NPI/tax ID No.	<input type="text"/>				
Name of billing provider	<input type="text"/>				
Billing provider NPI No.	<input type="text"/>				
Is this a request for recertification?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
CPT code	<input type="text"/>	No. of visits	<input type="text"/>	J code	<input type="text"/>
				No. of units	<input type="text"/>

Provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am either the prescribing provider or duly authorized to act on behalf of the provider identified in the Prescriber information section of this form. Any attached statement on 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.

Signature of provider or individual duly authorized to act on behalf of the provider:

Printed legal name and title of signatory above

<input type="text"/>	Date	<input type="text"/>
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(The form can either be signed by hand and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.)