



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
 P.O. Box 2586, Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Headache Therapy (Butalbital Combination Agents and Ergot Alkaloids) 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 Combination Agents

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> butalbital/acetaminophen (25 mg/325 mg) | <input type="checkbox"/> butalbital/acetaminophen/caffeine/codeine (50 mg/325 mg/40 mg/30 mg) > 20 units/month, < 18 years of age |
| <input type="checkbox"/> butalbital/acetaminophen (50 mg/300 mg) | <input type="checkbox"/> butalbital/acetaminophen/caffeine (50 mg/300 mg/40 mg) |
| <input type="checkbox"/> butalbital/acetaminophen (50 mg/325 mg) | <input type="checkbox"/> butalbital/acetaminophen/caffeine capsule, tablet (50 mg/325 mg/40 mg) > 20 units/month, < 18 years of age |
| <input type="checkbox"/> butalbital/acetaminophen/caffeine (50 mg/300 mg/40 mg) | <input type="checkbox"/> butalbital/acetaminophen/caffeine capsule, tablet (50 mg/325 mg/40 mg) > 20 units/month, < 18 years of age |
| <input type="checkbox"/> butalbital/acetaminophen/caffeine capsule, tablet (50 mg/325 mg/40 mg) > 20 units/month, < 18 years of age | <input type="checkbox"/> butalbital/acetaminophen/caffeine solution |
| <input type="checkbox"/> butalbital/acetaminophen/caffeine/codeine (50 mg/300 mg/40 mg/30 mg) | <input type="checkbox"/> butalbital/acetaminophen/caffeine/codeine (50 mg/300 mg/40 mg/30 mg) |
| | <input type="checkbox"/> Other butalbital agents _____ |

Ergot Alkaloids

- | | |
|--------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> dihydroergotamine injection | <input type="checkbox"/> ergotamine/caffeine suppository |
| <input type="checkbox"/> dihydroergotamine nasal spray | <input type="checkbox"/> ergotamine/caffeine tablet |
| <input type="checkbox"/> ergotamine | |

Quantity requested per month _____

Dose, frequency, and duration of medication requested _____

Indication

- 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.

Drug name _____ Please describe the outcome. Inadequate response Adverse reaction
Briefly describe the details of inadequate response or adverse reaction.

Drug name _____ Please describe the outcome. Inadequate response Adverse reaction
Briefly describe the details of inadequate response or adverse reaction.

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

2. 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.

3. Is the member under the care of a neurologist? Yes No

4. 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 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 formulation over the covered agents, dosage formulation over conventional dosage forms, or use in the requested age group as appropriate.

Section III. Please complete for dihydroergotamine nasal spray requests.

1. Has the member tried intranasal sumatriptan?
 Yes. Please describe the outcome. Inadequate response Adverse reaction
Briefly describe the details of inadequate response or adverse reaction.

- No. Explain why intranasal sumatriptan is not appropriate in this member.

2. Has the member tried intranasal Zomig?
 Yes. Please describe the outcome. Inadequate response Adverse reaction
Briefly describe the details of inadequate response or adverse reaction.

- No. Explain why intranasal Zomig is not appropriate in this member.

Section IV. Please also complete for dihydroergotamine nasal spray requests exceeding 8 units/month.

1. Is the member under the care of a neurologist? Yes No
2. 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.

Section V. Please complete for ergotamine and ergotamine/caffeine tablet requests.

1. Has the member tried sumatriptan tablets?
 Yes. Please describe the outcome. Inadequate response Adverse reaction
Briefly describe the details of inadequate response or adverse reaction.

- No. Explain why sumatriptan tablets are not appropriate in this member.

2. Has the member tried rizatriptan?
 Yes. Please describe the outcome. Inadequate response Adverse reaction
Briefly describe the details of inadequate response or adverse reaction.

- No. Explain why rizatriptan is not appropriate in this member.

Section VI. Please complete for dihydroergotamine injection and ergotamine/caffeine suppository requests.

1. Please describe clinical rationale for the use of the requested dosage formulation.

2. For dihydroergotamine injection requests only, has the member tried sumatriptan injection?
 Yes. Please describe the outcome. Inadequate response Adverse reaction
Briefly describe the details of inadequate response or adverse reaction.

- No. Explain why sumatriptan injection is not appropriate in this member.

3. For ergotamine/caffeine suppository requests only, has the member tried intranasal sumatriptan?

Yes. Please describe the outcome. Inadequate response Adverse reaction

Briefly describe the details of inadequate response or adverse reaction.

No. Explain why intranasal sumatriptan is not appropriate in this member.

Section VII. 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.

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 _____