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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

Topical Antiviral 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

☐ acyclovir ointment
☐ Denavir (penciclovir cream)
☐ Xerese (acyclovir/hydrocortisone cream)
☐ Zovirax (acyclovir cream)

Please note: Denavir, Xerese and Zovirax cream are FDA approved for orolabial herpes and acyclovir ointment is FDA-approved for genital herpes.

Frequency of application requested _____

Number of tubes requested/month _____ ☐ 5 gram tube ☐ 15 gram tube ☐ 30 gram tube

Duration of therapy requested _____

Indication (check all that apply)

☐ Genital herpes (HSV-2)
☐ Orolabial herpes (HSV-1, cold sores)
☐ Other (please indicate) _____

Section I. Please complete for any agent.

Has the member had a trial with oral antiviral agent(s) (acyclovir, famciclovir, valacyclovir)?

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

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.

_____

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.

_____

☐ No. Please explain contraindication to oral antiviral therapy or clinical rationale for not using oral antiviral therapy in this member.

_____

Section II. Please complete for requests > one tube per month.

Please explain medical necessity for exceeding one tube per month.

_____

_____

_____

_____

Section III. Please include any other pertinent information (if needed).

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Section IV. 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 _____