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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

Nonsteroidal Anti-Inflammatory Drugs (NSAID) 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

Section I. Medication requested

- ☐ Cambia (diclofenac powder for solution)
- ☐ celecoxib < 60 years of age
- ☐ diclofenac extended-release
- ☐ diclofenac/misoprostol < 60 years of age
- ☐ diclofenac potassium
- ☐ diclofenac topical solution
- ☐ diflunisal
- ☐ Duexis (ibuprofen/famotidine) < 60 years of age
- ☐ Dyloject (diclofenac injection)
- ☐ etodolac extended-release
- ☐ fenoprofen
- ☐ Flector (diclofenac topical patch)
- ☐ Indocin (indomethacin suspension)
- ☐ indomethacin extended-release
- ☐ ketoprofen extended-release
- ☐ ketorolac > 20 units/month
- ☐ meclofenamate
- ☐ mefenamic acid
- ☐ meloxicam suspension
- ☐ naproxen controlled-release
- ☐ naproxen EC
- ☐ naproxen suspension ≥ 12 years of age
- ☐ oxaprozin
- ☐ piroxicam
- ☐ salsalate
- ☐ Sprix (ketorolac nasal spray)
- ☐ Tivorbex (indomethacin 20 mg, 40 mg)
- ☐ tolmetin
- ☐ Vimovo (naproxen/esomeprazole) < 60 years of age
- ☐ Vivlodex (meloxicam capsule)
- ☐ Zipsor (diclofenac 25 mg capsule)
- ☐ Zorvolex (diclofenac 18 mg, 35 mg capsule)
- ☐ Other: _____

Dose, frequency, and duration of requested drug _____

Indications _____

Section II. Please complete for all requests as needed. Please provide the following information regarding previous generic NSAID trials.

Drug name ______________________________________ Dates/duration of generic use ____________________
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other Details of adverse reaction, inadequate response, or other ____
____

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Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other Details of adverse reaction, inadequate response, or other ____
____

Drug name ______________________________________ Dates/duration of generic use ____________________
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other Details of adverse reaction, inadequate response, or other ____
____

Drug name ______________________________________ Dates/duration of generic use ____________________
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other Details of adverse reaction, inadequate response, or other ____
____

Section III. Celecoxib and topical product requests

1. Has the member tried generic NSAIDs (three for celecoxib requests or two for topical product requests)?
   ☐ Yes, Complete Section II. ☐ No, Please indicate below why not.
   Is the member at a risk for a clinically significant gastrointestinal event, as defined by one of the following?
   ☐ **Yes** (Check one) Previous history of ☐ Major GI bleed ☐ Perforation ☐ Obstruction ☐ Peptic ulcer
   Dates: ____
   ☐ **Concomitant therapy with any of the following** (Check one)
   ☐ Aspirin ☐ Oral corticosteroid: dose, frequency and duration __________________________ ☐ Warfarin
   ☐ **No.** Please explain why member is not a candidate for generic NSAIDs. ____________________________
2. If the request is for a topical product, has the member tried acetaminophen?
   ☐ Yes, Please complete below.
   Dates/duration of use ____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Details of adverse reaction, inadequate response, or other ____
   ☐ No, Please indicate why not. ____

Section IV. Extended release products, solutions, suspensions, and diclofenac/misoprostol

Please provide clinical rationale for requiring an extended-release product, solution, suspension, or diclofenac/misoprostol over other available immediate release products, solid dosage formulations, or single-entity products. For suspension formulations, please provide the outcome of a trial with or contraindication to the use of ibuprofen suspension.

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Note: You may be asked to provide supporting documentation (e.g., copies of medical records, office notes).

Section V. Duexis, Sprix, and Vimovo Requests

Please attach medical records/office notes documenting medical necessity. A trial with concurrent therapy of ibuprofen and famotidine is required for Duexis requests. A trial of ketorolac tablets or injection is required for Sprix requests. A trial with concurrent therapy of naproxen and omeprazole is required for Vimovo requests.

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Section VI. 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 _____