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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

Dermatological Agents (Topical Chemotherapy and Genital Wart Therapy) 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

☐ Condylox Gel (podofilox gel)
☐ diclofenac 3% gel
☐ fluorouracil 0.5% cream
☐ fluorouracil 5% cream
☐ imiquimod 3.75% cream
☐ imiquimod 5% cream
☐ Picato (ingenol gel)
☐ Tolak (fluorouracil 4% cream)
☐ Veregen (sinecatechins)
☐ Zyclara (imiquimod 2.5% cream)

Dose of medication requested _____

Frequency of medication requested _____

Duration of medication requested _____

Indication (Check all that apply.)

☐ Actinic keratosis
☐ Superficial basal cell carcinoma
☐ External genital warts
☐ Perianal warts
☐ Other _____
(Attach a letter regarding medical necessity.)

Section I. Please complete for treatment of actinic keratosis with diclofenac 3% gel, fluorouracil 5% cream, Picato, Tolak, or Zyclara.

Has the member tried topical fluorouracil and experienced an adverse reaction or inadequate response?

☐ Yes. If yes, please document drug name, dose and frequency, dates/duration of use, and outcome.
Drug name _____ Dose and Frequency _____
Dates/Duration _____ Outcome _____

☐ No. Please document if there is a contraindication to topical fluorouracil therapy.

_____

_____

If the request is for Zyclara, has the member tried imiquimod 5% cream and experienced an adverse reaction or inadequate response?

☐ Yes. If yes, please document the dates/duration of use, and outcome.
Dates/Duration _____ Outcome _____

☐ No. (Please explain why.) _____

Section II. Please complete for treatment of superficial basal cell carcinoma with fluorouracil 5% cream.

Has the member tried fluorouracil solution and experienced an adverse reaction or inadequate response?

☐ Yes. If yes, please document dose and frequency, dates/duration of use, and outcome.
Dose and Frequency _____ Dates/Duration _____
Outcome _____

☐ No. Please document if there is a contraindication to fluorouracil solution.

_____

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Section III. Please complete for treatment of external genital warts or perianal warts with imiquimod 3.75% cream, imiquimod 5% cream, Veregen, or Zyclara.

Has the member tried topical podofilox, or podophyllum resin applied by a provider and experienced an adverse reaction or inadequate response?

☐ Yes. If yes, please document drug name, dose and frequency, dates/duration of use, and outcome.
Drug name _____ Dose and Frequency _____
Dates/Duration _____ Outcome _____

☐ No. Please document if there is a contraindication to topical podofilox or podophyllum resin.

_____

_____

If the request is for imiquimod 3.75% cream or Zyclara, has the member tried imiquimod 5% cream and experienced an adverse reaction or inadequate response?

☐ Yes. If yes, please document the dates/duration of use, and outcome.
Dates/Duration _____ Outcome _____

☐ No. (Please explain why.) _____

Section IV. Please complete for treatment of external genital warts with Condylox Gel.

Has the member tried podofilox solution and experienced an adverse reaction or inadequate response?

☐ Yes. If yes, please document dose and frequency, dates/duration of use, and outcome.
Dose and Frequency _____ Dates/Duration _____
Outcome _____

☐ No. (Please explain why.)

_____

_____

Section V. 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.

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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 _____