



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 Immune Suppressants 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](http://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

Eucrisa (crisaborole)  
 Frequency of application \_\_\_\_\_ Number of tubes requested/month \_\_\_\_\_  
 Tube size \_\_\_\_\_

#### Indication (Check all that apply.)

Atopic dermatitis. Please provide affected area(s) \_\_\_\_\_  
 Other (please indicate) \_\_\_\_\_

### Section I. Please complete for requests for the diagnosis of atopic dermatitis.

- Has the member had a trial with a superpotent or potent topical corticosteroid?
  - Yes. Please list the 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.  
 \_\_\_\_\_
  - No. Does the member have a contraindication to a superpotent or potent topical corticosteroid? Please explain.  
 \_\_\_\_\_
- Has the member had a trial with a topical calcineurin inhibitor?
  - Yes. Please list the 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.  
 \_\_\_\_\_

No. Does the member have a contraindication to a topical calcineurin inhibitor? Please explain.

*\* Please attach a letter documenting additional trials as necessary.*

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**Section II. Please complete for requests exceeding established quantity limits.**

Please explain medical necessity for exceeding the quantity limit.

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**Section III. 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*

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**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 \_\_\_\_\_