



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 Corticosteroids 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

#### Class I Superpotent products (See Sections I., II., and III.)

- |  |   |
|--|---|
| <input type="checkbox"/> clobetasol propionate (Clobex, Olux, Olux-E):<br>foam, gel, lotion, shampoo, shampoo-kit, spray | <input type="checkbox"/> flurandrenolide (Cordran): tape                |
| <input type="checkbox"/> diflorasone: ointment   | <input type="checkbox"/> halobetasol (Lexette, Ultravate): foam, lotion |
| <input type="checkbox"/> fluocinonide (Vanos): cream (0.1%)  | <input type="checkbox"/> halobetasol/lactic acid (Ultravate X): cream   |

#### Class II Potent products (See Sections I., II., and III.)

- |   |   |
|---|---|
| <input type="checkbox"/> amcinonide: ointment   | <input type="checkbox"/> diflorasone (Apexicon-E): cream      |
| <input type="checkbox"/> betamethasone dipropionate (Sernivo): spray                              | <input type="checkbox"/> halcinonide (Halog): cream, ointment |
| <input type="checkbox"/> desoximetasone (Topicort): cream, ointment spray (0.25%),<br>gel (0.05%) |   |

#### Class III Upper Mid-Strength Potent products (See Sections I., II., and III.)

- |   |   |
|---|---|
| <input type="checkbox"/> amcinonide: cream                                  | <input type="checkbox"/> diflorasone: cream |
| <input type="checkbox"/> betamethasone valerate (Luxiq): foam               |   |
| <input type="checkbox"/> desoximetasone (Topicort): cream, ointment (0.05%) |   |

#### Class IV Mid-Strength Potent products (See Sections I., II., and III.)

- |   |   |
|---|---|
| <input type="checkbox"/> clocortolone (Cloderm): cream        | <input type="checkbox"/> flurandrenolide: ointment              |
| <input type="checkbox"/> fluocinolone (Synalar): ointment-kit | <input type="checkbox"/> triamcinolone: ointment (0.05%), spray |

#### Class V Lower Mid-Strength Potent products (See Sections I., II., and III.)

- |  |   |
|--|---|
| <input type="checkbox"/> fluocinolone (Capex, Synalar): cream-kit, shampoo | <input type="checkbox"/> hydrocortisone butyrate: lotion          |
| <input type="checkbox"/> flurandrenolide: cream, lotion                    | <input type="checkbox"/> hydrocortisone probutate (Pandel): cream |
| <input type="checkbox"/> fluticasone propionate (Cutivate): lotion         |   |

#### Class VI Mild Potent products (See Sections I., II., and III.)

- |   |   |
|---|---|
| <input type="checkbox"/> desonide (Desonate): gel | <input type="checkbox"/> fluocinolone (Synalar): solution-kit |
|---|---|

**Class VII Least Potent products** (See Sections I., II., and III.)

hydrocortisone: solution

**Combination products**

betamethasone/calcipotriene (Enstilar, Taclonex): foam, ointment, scalp suspension       neomycin/fluocinolone: cream, cream-kit

**Drug, strength, and formulation requested** \_\_\_\_\_

**Frequency and duration of therapy** \_\_\_\_\_ **Drug NDC (if known)** \_\_\_\_\_

**Diagnosis and/or indication** \_\_\_\_\_

**Section I. Please complete for all requests, excluding combination products.**

Has the member had a trial with all generic topical corticosteroids of the same formulation and potency range?

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

Drug name, strength, and formulation \_\_\_\_\_ 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, strength, and formulation \_\_\_\_\_ 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, strength, and formulation \_\_\_\_\_ Dates/duration of use \_\_\_\_\_

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Briefly describe details of adverse reaction or inadequate response.

Drug name, strength, and formulation \_\_\_\_\_ 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, strength, and formulation \_\_\_\_\_ 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 or clinical rationale for not using other generic topical corticosteroid(s) in this member.

**Section II. Please complete for foam and shampoo formulations in scalp-related conditions.**

Has the member had a trial with one generic topical corticosteroid of a similar formulation and similar or greater potency range?

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

Drug name, strength, and formulation \_\_\_\_\_ 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 or clinical rationale for not using other generic topical corticosteroid(s) for this member.

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**Section III. Please complete for foam, gel, kit, shampoo, solution, spray, and tape formulations.**

Explain medical necessity for the requested formulation.

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**Section IV. Please complete for combination products.**

Provide compelling clinical rationale for why the combination product would offer a therapeutic advantage over the individual agents.

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**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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*\*Attach a letter with additional information regarding medication trials as applicable.*

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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 \_\_\_\_\_