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Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Ophthalmic Anti-Allergy and Anti-Inflammatory Agents 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

Ophthalmic Anti-Allergy Agents (Section I)

- ☐ Alocril (nedocromil)
- ☐ Alomide (lodoxamide)
- ☐ Alrex (loteprednol 0.2%)
- ☐ Bepreve (bepotastine)
- ☐ Emadine (emedastine)
- ☐ epinastine
- ☐ Lastacaft (alcaftadine)
- ☐ olopatadine 0.1% eye drops
- ☐ olopatadine 0.2% eye drops
- ☐ Pazeo (olopatadine 0.7% eye drops)

Miscellaneous (Section IV)

- ☐ Lacrisert (hydroxypropyl cellulose ophthalmic insert)
- ☐ Restasis (cyclosporine ophthalmic)
- ☐ Xiidra (lifitegrast)

Ophthalmic Non-Steroidal Anti-Inflammatory Agents (Section II)

- ☐ Acuvail (ketorolac 0.45% ophthalmic solution)
- ☐ bromfenac 0.09%
- ☐ Bromsite (bromfenac 0.075%)
- ☐ Ilevro (nepafenac 0.3% ophthalmic solution)
- ☐ Nevanac (nepafenac 0.1% ophthalmic solution)
- ☐ Prolensa (bromfenac 0.07%)

Ophthalmic Corticosteroids (Section III)

- ☐ Durezol (difluprednate)
- ☐ loteprednol 0.5% *Complete Section I or III, as applicable*
- ☐ Maxidex (dexamethasone ophthalmic solution)
- ☐ Vexol (rimexolone)

Other Medication

- ☐ Other* _____

**If request is for a non-preferred brand name or generic product, please attach supporting documentation (e.g., copies of medical records and/or office notes regarding adverse reaction or inadequate response to the preferred product).*

Dose, frequency, and duration of requested drug _____

Indication (Check all that apply.)

- ☐ Allergic conjunctivitis (seasonal or perennial)
- ☐ Anterior uveitis
- ☐ Keratoconjunctivitis sicca
- ☐ Post-operative pain and/or inflammation following ocular surgery
- ☐ Vernal conjunctivitis and/or vernal keratitis
- ☐ Other (Please indicate.) _____

Symptoms and symptom frequency _____

Section I. Please complete for all requests for ophthalmic anti-allergy agents.

For members ≥ 2 to < 3 years of age, for all requests except generic epinastine, please complete question 1.
For members ≥ 3 years of age, please complete questions 1 through 4 (please note, for requests for Alrex, generic epinastine, loteprednol 0.5%, and generic olopatadine 0.1% eye drops, only questions 3 and 4 are required).

1. Has the member had a trial with epinastine?
   ☐ Yes. Please list the dates/duration of trials and outcomes.* Dates/duration of trial _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Please explain if there is a contraindication to this trial. _____
2. Has the member had a trial with olopatadine eye drops?
   ☐ Yes. Please list the dates/duration of trials and outcomes.* Dates/duration of trial _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Please explain if there is a contraindication to this trial. _____
3. Has the member had a trial with azelastine ophthalmic solution?
   ☐ Yes. Please list the dates/duration of trials and outcomes.* Dates/duration of trial _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Please explain if there is a contraindication to this trial. _____
4. Has the member had a trial with ketotifen?
   ☐ Yes. Please list the dates/duration of trials and outcomes.* Dates/duration of trial _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Please explain if there is a contraindication to this trial. _____

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

Section II. Please complete for all requests for ophthalmic non-steroidal anti-inflammatory agents.

Has the member had a trial with ophthalmic ketorolac, diclofenac or flurbiprofen?
☐ Yes. Please list the drug name, dates/duration of trials and outcomes below.*
Drug name _____ Dates/duration of trial _____
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
Briefly describe details of adverse reaction, inadequate response, or other.
_____
☐ No. Please explain if there is a contraindication to this trial. _____

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

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Section III. Please complete for all requests for ophthalmic corticosteroids.

1. Has the member had a trial with a topical corticosteroid for ophthalmic use that is available without prior authorization?
   ☐ Yes. Please list the drug name, dates/duration of trials and outcomes below.*
   Drug name _____ Dates/duration of trial _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Please explain if there is a contraindication to this trial. _____
2. Is the member at risk for or does the member currently have intraocular hypertension?
   ☐ Yes. Please explain. _____ ☐ No

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

Section IV. Please complete for all requests for Lacrisert, Restasis, and Xiidra.

1. Has the member had a trial with artificial tear preparations? Please note, for Restasis requests, a trial with one artificial tear preparation is sufficient.
   ☐ Yes. Please list the drug name, dates/duration of trials and outcomes below.*
   Drug name _____ Dates/duration of trial _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   Drug name _____ Dates/duration of trial _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Please explain if there is a contraindication to these trials. _____
2. For Xiidra requests, has the member had a trial with Restasis?
   ☐ Yes. Please list the dates/duration of trials and outcomes below.*
   Dates/duration of trial _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Please explain if there is a contraindication to this trial. _____
3. For Restasis and Xiidra requests exceeding quantity limits, please provide a clinical rationale for dosing over the FDA-approved regimen.
   _____

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

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 _____