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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

Pediculicides and Scabicides 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

☐ crotamiton lotion ☐ lindane shampoo ☐ malathion ☐ Sklice (ivermectin lotion) ☐ spinosad

Dose, frequency and duration of medication requested _____

Indication

☐ Crab lice ☐ Head lice ☐ Scabies Other (please indicate) _____

Section I. Please complete for lindane shampoo requests.

1. Has the member had a trial with a permethrin or piperonyl butoxide/pyrethrin product?
   ☐ Yes. Please list the drug name, dates/duration of trials, and outcomes below.*
   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, contraindication, or other.
   _____
   ☐ No. Please describe clinical rationale for not using permethrin and piperonyl butoxide/pyrethrin for this member. _____
2. Has the member had a trial with malathion?
   ☐ Yes. Please list the drug name, dates/duration of trials, and outcomes below.*
   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, contraindication, or other.
   _____
   ☐ No. Please describe clinical rationale for not using malathion for this member.
   _____

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

Section II. Please complete for crotamiton lotion requests.

1. Has the member had a trial with a permethrin 5% product?
   - ☐ Yes. Please list the drug name, dates/duration of trials, and outcomes below.*
     Drug name _____ Dates/duration of use _____
     Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
     Briefly describe details of adverse reaction, inadequate response, contraindication, or other.
     _____
   - ☐ No. Please describe clinical rationale for not using permethrin 5% for this member. _____
2. Has the member had a trial with oral ivermectin?
   - ☐ Yes. Please list the drug name, dates/duration of trials, and outcomes below.*
     Drug name _____ Dates/duration of use _____
     Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
     Briefly describe details of adverse reaction, inadequate response, contraindication, or other.
     _____
   - ☐ No. Please describe clinical rationale for not using oral ivermectin for this member.
     _____
3. Has the member had a trial with crotamiton cream?
   - ☐ Yes. Please list dates/duration of trials, and outcomes below. *
     Dates/duration of use _____
     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 describe clinical rationale for use of the requested formulation over cream formulation.
     _____

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

Section III. Please complete for Sklice and spinosad requests.

Has the member had a trial with permethrin, or piperonyl butoxide/pyrethrin?

- ☐ Yes. Please list the drug name, dates/duration of trials, and outcomes below.*
  Drug name _____ Dates/duration of use _____
  Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
  Briefly describe details of adverse reaction, inadequate response, contraindication, or other.
  _____
- ☐ No. Please describe clinical rationale for not using permethrin, piperonyl butoxide/pyrethrin and malathion for this member.
  _____

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

Section IV. Please complete for malathion requests

Has the member had a trial with permethrin or piperonyl butoxide/pyrethrin?

- ☐ Yes. Please list the drug name, dates/duration of trials, and outcomes below.*
  Drug name _____ Dates/duration of use _____
  Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
  Briefly describe details of adverse reaction, inadequate response, contraindication, or other.
  _____
- ☐ No. Please describe clinical rationale for not using permethrin and piperonyl butoxide/pyrethrin for this member.
  _____

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

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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.

_____

_____

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 _____