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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

Nonsteroidal Anti-Inflammatory Drugs (NSAID) 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

☐ Cambia (diclofenac powder for solution)
☐ diclofenac/misoprostol < 60 years of age
☐ diclofenac topical patch
☐ diclofenac topical solution
☐ Duexis (ibuprofen/famotidine) < 60 years of age
☐ etodolac extended-release
☐ fenoprofen
☐ Indocin (indomethacin suspension)
☐ ketoprofen extended-release
☐ ketorolac > 20 units/month
☐ ketorolac nasal spray
☐ meclofenamate
☐ meloxicam suspension
☐ naproxen controlled-release
☐ naproxen suspension < 13 years of age
☐ naproxen/esomeprazole < 60 years of age
☐ Qmiiz (meloxicam orally disintegrating tablet)
☐ Relafen DS (nabumetone 1000 mg)
☐ salsalate
☐ tolmetin
☐ Vivlodex (meloxicam capsule)
☐ Zipsor (diclofenac 25 mg capsule)
☐ Zorvolex (diclofenac 18 mg, 35 mg capsule)
☐ Other* _____

Dose, frequency, and duration of medication requested _____

Indication _____

** 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).*

Section I. Please complete for topical product requests.

1. Has the member tried diclofenac 1% gel?
   ☐ Yes. Please complete Section IV.
   ☐ No. Please indicate why not. _____
2. Has the member tried two different NSAIDs?
   ☐ Yes. Please complete Section IV.
   ☐ No.

3. If you answered "No" to the question above, is the member at risk for a clinically significant gastrointestinal event, as defined by one of the following?
   ☐ Yes
      ☐ Previous history of ☐ Major GI bleed ☐ Perforation ☐ Obstruction ☐ Peptic ulcer
         Date(s) _____
      ☐ Concomitant therapy with any of the following
         ☐ Aspirin ☐ Warfarin ☐ Oral corticosteroid (specify) _____
         Dose, frequency, and duration _____
      ☐ Other risk factor (specify) _____
   ☐ No. Please explain why member is not a candidate for different NSAIDs. _____
      _____
4. Has the member tried acetaminophen?
   ☐ Yes. Dates/duration of use _____
      Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
      Details of adverse reaction, inadequate response, or other. _____
   ☐ No. Please indicate why not. _____

Section II. Please complete for controlled-release products, extended-release products, solution products, orally disintegrating products, and suspension products.

1. Please provide clinical rationale for the use of the requested formulation instead of other available immediate-release products or solid dosage formulations.
   _____
2. For solution products and suspension products, has the member tried ibuprofen suspension?
   ☐ Yes. Please complete Section IV.
   ☐ No. Please indicate why not. _____
3. For Cambia, has the member tried naproxen suspension?
   ☐ Yes. Please complete Section IV.
   ☐ No. Please indicate why not. _____

Section III. Please complete for diclofenac/misoprostol, Duexis, ketorolac nasal spray, naproxen/esomeprazole, and Relafen DS requests.

Please attach medical records/office notes documenting medical necessity. A trial with concurrent therapy of diclofenac and misoprostol is required for diclofenac/misoprostol requests. A trial of ketorolac tablets or injection is required for ketorolac nasal spray requests. A trial with concurrent therapy of ibuprofen and famotidine is required for Duexis requests. A trial with concurrent therapy of naproxen and omeprazole is required for naproxen/esomeprazole requests. A trial of an equivalent dose of nabumetone 500 mg or 750 mg is required for Relafen DS requests.

Section IV. Please complete for all requests as needed.

Please provide the following information regarding previous NSAID trials.*

Drug name _____ Dates/duration of use _____
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
Details of adverse reaction, inadequate response, or other. _____
_____

Drug name _____ Dates/duration of use _____
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
Details of adverse reaction, inadequate response, or other. _____
_____

over

Drug name _____ Dates/duration of use _____

Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

Details of adverse reaction, inadequate response, or other. _____

_____

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

Section V. Please complete for ketorolac requests exceeding the quantity limit.

Please describe the medical necessity for exceeding the quantity limit.

_____

Section VI. 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 _____