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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

Topical Anesthetics
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

☐ lidocaine ointment Dose/frequency _____

☐ lidocaine 5% patch > 90 patches/month
Dose/frequency _____ patch/patches every 12 hours/24 hours (with 12 hours off)
☐ Other _____

☐ Qutenza (capsaicin high dose patch)^ Dose/frequency _____

☐ Synera (lidocaine/tetracaine) > 4 patches/month Dose/frequency _____

☐ Zingo (lidocaine powder intradermal injection system) Dose/frequency _____
Number of systems requested/month _____

☐ Ztlido (lidocaine 1.8% patch) Dose/frequency _____
Number of patches requested/month _____

^This drug is available through the health care professional who administers the drug. MassHealth does not pay for this drug to be dispensed through a retail pharmacy.

Indication (Check all that apply.)

☐ Dermatological procedure requiring local analgesia. Please describe. _____

☐ Post herpetic neuralgia

☐ Other _____
If other, does the type of pain being treated have a neuropathic component? ☐ Yes ☐ No

Please list all other medications currently prescribed for the member for this indication.

_____

_____

Section I. Please complete for requests for lidocaine patch, Synera, Zingo, and Ztlido exceeding quantity limits.

Please describe the medical necessity for using the requested agent above the quantity limit.

_____

Section II. Please complete for Zingo requests.

Has the member had a trial with Synera (lidocaine/tetracaine)?

☐ Yes. Please list the dates/duration of trial and outcome 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, contraindication, or other.

_____

☐ No. Please describe clinical rationale for not using Synera (lidocaine/tetracaine) in this member.

_____

Section III. Please complete for Ztlido requests.

Has the member had a trial with lidocaine 5% patches?

☐ Yes. Please list the dates/duration of trial and outcome 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, contraindication, or other.

_____

☐ No. Please describe clinical rationale for not using lidocaine 5% patches in this member.

_____

Section IV. Please complete for Qutenza requests.

1. Has the member had a trial with lidocaine patch and a topical capsaicin agent?

☐ Yes. Please list the drug name, dates/duration of trials, and outcomes below.*

Drug name _____ Dates/duration of use _____ Dose and frequency _____

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

Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

_____

Drug name _____ Dates/duration of use _____ Dose and frequency _____

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 lidocaine patch and a topical capsaicin agent in this member.

_____

2. Has the member had a trial with a tricyclic antidepressant and an anticonvulsant (gabapentin or pregabalin)?

☐ Yes. Please list the drug name, dates/duration of trials, and outcomes below.*

Drug name _____ Dates/duration of use _____ Dose and frequency _____

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

Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

_____

Drug name _____ Dates/duration of use _____ Dose and frequency _____

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 medical necessity for transdermal formulation.

_____

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

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Section V. Please complete for lidocaine ointment requests.

Please describe the medical necessity for use of the requested agent.

_____

_____

_____

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 _____