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

Print Clear

Opioids/Acetaminophen Analgesic 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 opioid and acetaminophen analgesic 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

Drug name _____ **Dose and frequency** _____ **Duration of therapy** _____

Indication _____

Has the prescriber evaluated Massachusetts Prescription Awareness Tool (MassPAT) data, risk factors, and potential risk factors for abuse/misuse in their assessment of this member? ☐ Yes ☐ No

For mid-level practitioners (e.g., nurse practitioners, physician assistants), please provide the name and specialty of the collaborating physician. _____

Is this member a referral candidate for care coordination? ☐ Yes ☐ No

If yes, MassHealth will offer coordination services to this member. Please describe which additional behavioral health service would be beneficial.

_____

Section I. Please complete for oxycodone extended-release (ER) tablet (Oxycontin) requests.*

Has the member tried a long-acting morphine product or a fentanyl transdermal product?

☐ Yes. Drug _____ Dose and frequency _____ Dates of use _____ Outcome _____

☐ No. If morphine and fentanyl transdermal are contraindicated in this member, please describe. _____

_____

Section II. Please complete for methadone (Dolophine, Methadose) requests.*

1. Has the member tried a long-acting morphine product?
   ☐ Yes. Dose and frequency _____ Dates of use _____ Outcome _____
   ☐ No. If morphine is contraindicated in this member, please describe. _____

_____

2. Has the member tried a fentanyl transdermal product?
   ☐ Yes. Dose and frequency _____ Dates of use _____ Outcome _____
   ☐ No. If fentanyl transdermal is contraindicated in this member, please describe. _____
   _____
3. If the answer to questions 1 and 2 is no, please provide clinical rationale for the use of methadone over other long-acting opioids. _____
4. Is the member opioid naive? ☐ Yes ☐ No
5. Has the member had a baseline ECG showing a normal QTc interval? ☐ Yes ☐ No

Section III. Please complete for requests for fentanyl nasal spray (Lazanda), fentanyl sublingual tablet (Abstral), fentanyl sublingual spray (Subsys), fentanyl transmucosal system (Actiq), fentanyl buccal tablet (Fentora), oxymorphone immediate-release (IR) (Opana IR), and tapentadol (Nucynta).*

1. Is the member currently maintained on a long-acting opioid regimen?
   ☐ Yes. Drug _____ Dose and frequency _____ Dates of use _____
   ☐ No
2. Has the member tried the following agents? ☐ Yes. Please describe below.
   hydromorphone IR Dose and frequency _____ Dates of use _____ Outcome _____
   morphine IR Dose and frequency _____ Dates of use _____ Outcome _____
   oxycodone IR Dose and frequency _____ Dates of use _____ Outcome _____
   ☐ No. If hydromorphone, morphine, and oxycodone are contraindicated in this member, please describe.
   _____
3. If the request is for Abstral, fentanyl buccal tablet, Lazanda, or Subsys, has the member tried fentanyl transmucosal system (Actiq)?
   ☐ Yes. Dose and frequency _____ Dates of use _____ Outcome _____
   ☐ No. If fentanyl transmucosal system (Actiq) is contraindicated in this member, please describe.
   _____

Section IV. Please complete for requests for hydrocodone ER (Hysingla ER, Zohydro ER), hydromorphone ER (Exalgo), levorphanol tablet, morphine ER tablet (Arymo ER, Morphabond ER), morphine/naltrexone (Embeda), oxycodone ER capsule (Xtampza), oxymorphone ER, and tapentadol ER (Nucynta ER).*

1. Has the member tried the following agents? ☐ Yes. Please describe below.
   fentanyl transdermal Dose and frequency _____ Dates of use _____ Outcome _____
   morphine ER Dose and frequency _____ Dates of use _____ Outcome _____
   oxycodone ER Dose and frequency _____ Dates of use _____ Outcome _____
   ☐ No. If fentanyl transdermal, morphine ER, and oxycodone ER are contraindicated in this member, please describe. _____
2. If the request is for levorphanol tablet, please provide clinical rationale for the use of levorphanol over other long-acting opioids. _____

Section V. Please complete for morphine ER capsule (Kadian and generics) requests.*

Please provide clinical rationale for the use of the requested formulation instead of morphine controlled-release tablets. _____

Section VI. Please complete for meperidine (Demerol) requests.

Please attach documentation describing medical necessity due to allergy to morphine.

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Section VII. Please complete for requests for benzhydrocodone/acetaminophen, dihydrocodeine/acetaminophen/caffeine, dihydrocodeine/aspirin/caffeine (Synalgos-DC), hydrocodone/acetaminophen 300mg, hydrocodone 5 mg, 10 mg/ibuprofen, oxycodone/acetaminophen 300mg, oxycodone/acetaminophen ER (Xartemis XR), and oxycodone/ibuprofen.*

Please attach documentation of prior generic combination analgesic trials including hydrocodone/acetaminophen, oxycodone/acetaminophen, codeine/acetaminophen, and hydrocodone/ibuprofen.

Section VIII. Please complete for buprenorphine buccal film (Belbuca) requests.*

Has the member tried a long-acting morphine product?

☐ Yes. Dose and frequency _____ Dates of use _____ Outcome _____

☐ No. If morphine is contraindicated in this member or there is clinical rationale for the requested formulation, please describe. _____

Section IX. Please complete for fentanyl transdermal 37.5, 62.5, 87.5 mcg/hr requests.*

Please provide clinical rationale for use of requested formulation over other strengths. _____

_____

Section X. Please complete for butorphanol nasal spray requests.

Please attach documentation describing an adverse reaction or contraindication to all other short-acting opioids, or medical necessity for nasal spray formulation in addition to an adverse reaction or contraindication to morphine and oxycodone IR solutions.

Section XI. Please complete for tramadol ER (Conzip, Ultram ER) requests.

1. Please provide clinical rationale for use of an extended-release formulation. _____

   _____
2. Please attach documentation describing an inadequate response or adverse reaction to tramadol IR.

Section XII. Please complete for tramadol/acetaminophen (Ultracet) requests.

Please provide clinical rationale for use of the combination product over the separately available ingredients.

_____

_____

Section XIII. Please complete for tramadol 100 mg requests.

1. Please provide medical necessity for use of the requested strength. _____

   _____
2. Please attach documentation describing an inadequate response or adverse reaction to tramadol 50 mg at the requested dose.

Section XIV. Please complete for requests for codeine and tramadol products for members < 12 years old.

Please provide clinical rationale for use of a codeine and tramadol-containing product in a member < 12 years old.

_____

Section XV. Please complete for oxycodone IR (Oxaydo) requests.*

Please provide clinical rationale as to why the generically available oxycodone IR 5 mg scored tablets cannot be used. _____

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Section XVI. Please complete for requests for duplicate short-acting or long-acting opioids.

Please provide clinical rationale for duplicate therapy including plan to consolidate therapy.

_____

Section XVII. Please complete for requests above established dose limits.

For all opioids, please provide medical records documenting treatment plan including clinical rationale for high dose and titration of medication up to current dose. In addition, please provide a signed and dated patient-prescriber agreement and a consult from a pain specialist recommending the requested dose for this member. For acetaminophen and aspirin products, please provide a clinical rationale for the use above 4 grams per day. For ibuprofen products, please provide a clinical rationale for the use above 3.2 grams per day.

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Section XVIII. Please complete for requests for high dose short-acting opioids as monotherapy.

Please provide medical records documenting treatment plan including clinical rationale for use of high dose short-acting opioids without a long-acting opioid agent. In addition, please provide clinical rationale for high dose and titration of medication up to current dose, a signed and dated patient-prescriber agreement, and a consult from a pain specialist recommending the requested dose for this member.

_____

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Section XIX. Please complete for requests above established quantity limits.

Can the requested dose be obtained by using products within established quantity limits (i.e., for oxycodone ER 20 mg, 2 tablets twice daily could be consolidated to one oxycodone ER 40 mg tablet twice daily)?

☐ Yes ☐ No. If dose consolidation is not an option, please explain why. _____

_____

Section XX. Please complete for concurrent therapy with opioid dependence agents.

1. Are you the prescriber of both buprenorphine/naloxone or buprenorphine and the opioid? ☐ Yes ☐ No
2. Prior to continuing buprenorphine/naloxone or buprenorphine therapy, will the member be discontinuing the opioid(s)? ☐ Yes ☐ No
3. Please document the medical necessity for concurrent buprenorphine/naloxone or buprenorphine and opioid therapy. Please submit medical records supporting the medical necessity, including the specific pain that the current opioid is being used to treat.

   _____

   _____
4. Please document the complete treatment plan, including expected duration of therapy for this member in regard to acute pain management with concurrent buprenorphine/naloxone or buprenorphine and opioid therapy.

   _____

   _____

Section XXI. 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. If MassHealth pharmacy claims history of required trials is not available, medical records documenting such trials may be required.*

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 _____