



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 Vitamin D Analogues 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](http://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 and tube size

- calcipotriene cream (quantity > 60 grams/month)
  - 60 gram tube  120 gram tube
- calcipotriene ointment (quantity > 60 grams/month)
  - 60 gram tube  120 gram tube
- calcitriol ointment
  - 100 gram tube
- Sorilux (calcipotriene foam)
  - 60 gram tube  120 gram tube
- Other\*

#### Frequency of application

\_\_\_\_\_

#### Indication (Check all that apply.)

- Plaque psoriasis
  - Other (Please indicate.)
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\* 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 requests for calcitriol ointment and Sorilux.

1. Has the member had a trial with a topical corticosteroid?
  - Yes. Please list the drug name, dates/duration of use, and outcome of trial as noted below.\*  
 Drug name \_\_\_\_\_ Dates/duration of use \_\_\_\_\_  
 Did the member experience any of the following outcomes?  Adverse reaction  Inadequate response  
 Briefly describe details of adverse reaction or inadequate response. \_\_\_\_\_
  - No. Does the member have a contraindication to topical corticosteroids? Please explain.  
 \_\_\_\_\_

2. Has the member had a trial with calcipotriene cream, ointment, or scalp solution?

Yes. Please list the drug name, dates/duration of use, and outcome of trial as noted below.\*

Drug name \_\_\_\_\_ Dates/duration of use \_\_\_\_\_

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

Briefly describe details of adverse reaction or inadequate response. \_\_\_\_\_

No. Does the member have a contraindication to calcipotriene cream, ointment, and scalp solution?

Please explain.

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

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## Section II. Please complete for requests for quantities exceeding established quantity limits.

Please describe the clinical rationale for exceeding the quantity limit.

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## Section III. 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

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### 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 \_\_\_\_\_