



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

Ophthalmic Anti-Allergy and Anti-Inflammatory Agents 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

Ophthalmic Anti-Allergy Agents (Sections I and II)

- Alrex (loteprednol 0.2%)
- epinastine
- olopatadine 0.1% eye drops
- olopatadine 0.2% eye drops
- Pazeo (olopatadine 0.7% eye drops)
- Zerviate (cetirizine ophthalmic solution)

Ophthalmic Corticosteroids (Section IV)

- Durezol (difluprednate)
- Inveltys (loteprednol 1% suspension)
- Lotemax (loteprednol 0.5% gel, ointment)
- Lotemax SM (loteprednol 0.38% gel)

Other Medication

- Other* _____

**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).*

Dose, frequency, and duration of medication requested _____

Indication (Check all that apply.)

- Allergic conjunctivitis (seasonal or perennial)
- Anterior uveitis
- Keratoconjunctivitis sicca
- Post-operative pain and/or inflammation following ocular surgery
- Vernal conjunctivitis and/or vernal keratitis
- Other (Please indicate.) _____

Symptoms and symptom frequency _____

Section I. Please complete for olopatadine 0.2%, brand name Patanol, Pazeo, and Zerviate requests.

For members \geq two to $<$ three years of age, please complete question 1. For members \geq three years of age, please complete questions 2 and 3. For brand name Patanol requests, member must be \geq three years of age.

1. Has the member had a trial with two of the following: Alomide, Bepreve, epinastine, or Lastacaft?

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

Drug name _____ Dates/duration of trial _____

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

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

Drug name _____ Dates/duration of trial _____

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 explain if there is a contraindication to these trials. _____

2. Has the member had a trial with two of the following: Alocril, Alomide, azelastine ophthalmic solution, Bepreve, ketotifen, or Lastacaft?

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

Drug name _____ Dates/duration of trial _____

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

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

Drug name _____ Dates/duration of trial _____

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 explain if there is a contraindication to these trials. _____

3. Has the member had a trial with epinastine or olopatadine eye drops?

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

Drug name _____ Dates/duration of trial _____

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 explain if there is a contraindication to these trials. _____

Section II. Please complete for Alex, epinastine, and olopatadine 0.1% requests.

For epinastine requests, complete the question below if the member is \geq three years of age.

Has the member had a trial with azelastine ophthalmic solution, or ketotifen?

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

Drug name _____ Dates/duration of trial _____

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 explain if there is a contraindication to these trials. _____

Section III. Please complete for all requests for ophthalmic non-steroidal anti-inflammatory agents.

Has the member had a trial with ophthalmic diclofenac, flurbiprofen, ketorolac, or nepafenac 0.1%?

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

Drug name _____ Dates/duration of trial _____

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 explain if there is a contraindication to these trials. _____

Section IV. Please complete for all requests for ophthalmic corticosteroids.

Has the member had a trial with a topical corticosteroid for ophthalmic use that is available without prior authorization?

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

Drug name _____ Dates/duration of trial _____

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 explain if there is a contraindication to this trial. _____

Section V. Please complete for all requests for Cequa, Restasis Multidose, and Xiidra.

1. Has the member had a trial with Restasis 0.05% ophthalmic emulsion?

Yes. Please list the dates/duration of trials and outcomes.* Dates/duration of trial _____

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 explain if there is a contraindication to this trial. _____

2. For Restasis Multidose, please provide medical necessity for the use of the requested formulation instead of Restasis 0.05% ophthalmic emulsion. _____

3. For requests exceeding quantity limits, please provide a clinical rationale for dosing over the FDA-approved regimen. _____

Section VI. Please complete for all requests for Lacrisert.

Has the member had a trial with artificial tear preparations?

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

Drug name _____ Dates/duration of trial _____

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

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

Drug name _____ Dates/duration of trial _____

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 explain if there is a contraindication to these trials. _____

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

Section VII. 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 _____