



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
 P.O. Box 2586
 Worcester, MA 01613-2586

Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

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 provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Bextra, Celebrex, Vioxx, Mobic, and Arthrotec. In addition, PA is required for Ponstel (single-source brand-name NSAID) and any brand-name multiple-source NSAID that has an FDA "A"-rated generic equivalent as identified by the **Approved Drug Products with Therapeutic Equivalence Evaluations** (also called the "Orange Book"). Additional information about nonsteroidal use can be found within the MassHealth Drug List at www.mass.gov/masshealth.

Member information

Last name	First name	MI	MassHealth member ID #	Date of birth	Sex (Circle one.) f m
Member's place of residence <input type="checkbox"/> home <input type="checkbox"/> nursing facility					

Medication information

Please complete section 1 below **or** section 2 on back, depending on the drug requested.

1. Cox-2 Inhibitor/ Arthrotec request <input type="checkbox"/> Arthrotec (misoprostol/diclofenac) <input type="checkbox"/> Celebrex (celecoxib) <input type="checkbox"/> Bextra (valdecoxib) <input type="checkbox"/> Mobic (meloxicam) <input type="checkbox"/> Vioxx (rofecoxib)	Dose, frequency, and duration of requested drug	Drug NDC (if known)
	Is member under 60 years of age? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Indications (Check one.) <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Primary dysmenorrhea <input type="checkbox"/> Familial adenomatous polyposis (celecoxib only: FDA-approved) <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Acute pain <input type="checkbox"/> Other, specify _____		
Is member at risk for a clinically significant gastrointestinal event, as defined by one of the following?		
<input type="checkbox"/> Yes (Check one.)	<input type="radio"/> Previous history: <input type="checkbox"/> Major GI bleed <input type="checkbox"/> Perforation <input type="checkbox"/> Obstruction	Dates
	<input type="radio"/> Previous history of a peptic ulcer documented by endoscopy or radiograph	Dates
<input type="checkbox"/> Concomitant therapy with any of the following (Check one.)		
<input type="radio"/> Aspirin <input type="radio"/> Oral corticosteroid: dose, frequency, and duration _____ <input type="radio"/> Warfarin: dose, frequency, and duration _____		
<input type="checkbox"/> No. Has member tried two generic NSAID products?		
<input type="radio"/> Yes. Complete boxes 3A and 3B on back (Generic NSAID product courses).		
<input type="radio"/> No. Explain why not. _____ _____ _____ _____		

Medication information continued

2. Brand-name multiple-source NSAID or Ponstel request	Dose, frequency, and duration of requested drug	Drug NDC (if known)
Diagnosis pertinent to requested medication		
Has member tried two generic products?		
<input type="checkbox"/> Yes. Complete boxes 3A and 3B below (Generic NSAID product courses). <input type="checkbox"/> No. Explain why not.		

3. Generic NSAID product courses

A. Drug name	B. Drug name
Dates of generic use	Dates of generic use
Dose and frequency	Dose and frequency
Did member experience any of the following?	Did member experience any of the following?
<input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Other	<input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Other
Details of adverse reaction, inadequate response, or other	Details of adverse reaction, inadequate response, or other
_____	_____
_____	_____
_____	_____

Pharmacy information

Name	Pharmacy provider no.	Telephone ()	Fax ()
Address		City	State Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA #
Address			City	State Zip
E-mail address			Telephone ()	Fax ()

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.)

Date

DUR program use only

Reviewer's decision	<input type="checkbox"/> Approved	<input type="checkbox"/> Pended	<input type="checkbox"/> Denied
Comments/reasons for pended or denied decision _____			

