



Prior Authorization Request Administrative Information

Member information

Last name First name MI

Member ID Date of birth

Sex assigned at birth Female Male "X" or Intersex

Current gender Female Male Transgender male Transgender female Other

Place of residence Home Nursing facility Other

Race Ethnicity

Preferred spoken language Preferred written language

MassHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, creed, sexual orientation, or sex (including gender identity and gender stereotyping).

Plan contact information

Please indicate the member's MassHealth Plan and fax or submit this completed and signed form according to the Plan's contact information below.

MassHealth Fee-For-Service (FFS) Plan, Primary Care Clinician (PCC) Plan, Primary Care Accountable Care Organization (PCACO) Plan, and Children's Medical Security Plan

MassHealth Drug Utilization Review Program

Pharmacy: Fax: (877) 208-7428 - Tel: (800) 745-7318

MassHealth Managed Care Organization (MCO) and Accountable Care Partnership Plans (ACPP)

Fallon Health

Online Prior Authorization: go.covermy meds.com/OptumRx

Online Prior Authorization: providerportal.surescripts.net/ProviderPortal/optum

Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033

Health New England

Online Prior Authorization: go.covermy meds.com/OptumRx

Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545

Mass General Brigham Health Plan

Online Prior Authorization (Pharmacy Benefit Reviews): go.covermy meds.com/OptumRx

Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555

Online Prior Authorization (Medical Specialty Reviews): provider.massgeneralbrighamhealthplan.org

Medical Specialty Reviews: Fax: (888) 656-6671 - Tel: (833) 895-2611

Tufts Health Plan

Online Prior Authorization: point32health.promptpa.com

Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985

WellSense Health Plan

Online Prior Authorization: wellsense.org/providers/ma/pharmacy/prior-authorizations

Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822

Anticoagulant and Antiplatelet 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.

Medication information

Medication requested

Anticoagulants

- Eliquis (apixaban sprinkle capsule)
- Eliquis (apixaban tablet for oral suspension)
- Pradaxa (dabigatran oral pellet)
- rivaroxaban 2.5 mg tablet > 2 units/day
- rivaroxaban suspension ≥ 18 years
- Savaysa (edoxaban)

Antiplatelet

- Zontivity (vorapaxar)

Dose and frequency of medication requested

Duration requested

Indication for Anticoagulant (Check all that apply or include ICD-10 code, if applicable.)

- Nonvalvular atrial fibrillation
- Reduce the risk of major cardiovascular (CV) events in coronary artery disease (CAD)/peripheral artery disease (PAD)
- Reduce the risk of recurrence of DVT and PE
- Thromboprophylaxis in pediatric member with congenital heart disease after Fontan procedure
- Treatment of DVT
- Treatment of PE
- Treatment or reduction of risk of recurrent DVT and/or PE in pediatric member
- Other

Indication for Antiplatelet (Check all that apply or include ICD-10 code, if applicable.)

- Non-ST elevation myocardial infarction (MI)
- PAD
- ST elevation MI
- Other

Section I. Please complete for Pradaxa oral pellet requests.

1. Member's current weight Date
2. Has the member received or will the member receive ≥ five days of injectable or intravenous anticoagulation prior to starting the requested agent? Yes No
3. Has the member had a trial with rivaroxaban suspension or tablets?
 Yes. Please list the drug name, dose and frequency, dates/duration of trials, and outcomes below.

Drug name Dose and frequency 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, or other.

No. Please describe why rivaroxaban suspension or tablets are not appropriate for this member.

4. For members \geq eight years of age, has the member had a trial with dabigatran capsule?

Yes. Please list the dates/duration of trials and outcomes 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, or other.

No. Please describe why dabigatran capsule is not appropriate for this member, or describe if there is medical necessity for the oral pellet formulation.

Section II. Please complete for Savaysa requests.

1. Has the member had a trial with dabigatran capsule?

Yes. Please list the dates/duration of trials and outcomes 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, or other.

No. Please describe why dabigatran capsule is not appropriate for this member.

2. Has the member had a trial with Eliquis?

Yes. Please list the dates/duration of trials and outcomes 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, or other.

No. Please describe why Eliquis is not appropriate for this member.

3. Has the member had a trial with rivaroxaban?

Yes. Please list the dates/duration of trials and outcomes 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, or other.

No. Please describe why rivaroxaban is not appropriate for this member.

Section III. Please complete for rivaroxaban 2.5 mg tablet requests > 2 units/day.

Please describe the medical necessity for use above the established quantity limit.

Section IV. Please complete for rivaroxaban suspension requests for members ≥ 18 years of age.

Please describe the medical necessity for the suspension formulation of rivaroxaban.

Section V. Please complete for Zontivity requests.

1. Does the member have a history of stroke, transient ischemic attack, or intracranial hemorrhage?

Yes No

2. Is the member receiving concurrent aspirin and/or clopidogrel therapy?

Yes. Drug

Dose

Frequency

No

Section VI. Please complete for Eliquis sprinkle capsule or tablet for oral suspension requests.

1. Has the member received or will receive ≥ 5 days of anticoagulation prior to starting Eliquis?

Yes No

2. Is the members weight ≥ 2.6 kg and < 35 kg? Yes No

3. If no, is the members weight ≥ 35 kg? Yes No

4. If yes, has the member had a trial with Eliquis tablet?

Yes. Please list the dates/duration of trials and outcomes 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, or other.

No. Please describe why Eliquis tablet is not appropriate for this member.

4. If the members weight is ≥ 35 kg and the member has not had a trial with Eliquis tablet please provide medical necessity for the requested agent instead of formulation available without prior authorization.

Section VII. Please complete and provide documentation for exceptions to step therapy.

1. Is the alternative drug required under the step therapy protocol contraindicated, or will likely cause an adverse reaction in, or physical or mental harm to, the member? Yes No

If yes, briefly describe details of contraindication, adverse reaction, or harm.

2. Is the alternative drug required under the step therapy protocol expected to be ineffective based on the known clinical characteristics of the member and the known characteristics of the alternative drug regimen?

Yes No

If yes, briefly describe details of known clinical characteristics of member and alternative drug regimen.

3. Has the member previously tried the alternative drug required under the step therapy protocol, or another alternative drug in the same pharmacologic class or with the same mechanism of action, and such alternative drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?

Yes No

If yes, please provide details for the previous trial.

Drug name

Dates/duration of use

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

Briefly describe details of adverse reaction or inadequate response.

4. Is the member stable on the requested prescription drug prescribed by the healthcare provider, and switching drugs will likely cause an adverse reaction in, or physical or mental harm to, the member?

Yes. Please provide details.

No

Please continue to next page and complete Prescriber and Provider Information section.

Prior Authorization Request Prescriber and Provider Information

Prescriber information

Last name*	<input type="text"/>	First name*	<input type="text"/>	MI	<input type="text"/>
NPI*	<input type="text"/>	Individual MH Provider ID	<input type="text"/>		
DEA No.	<input type="text"/>	Office Contact Name	<input type="text"/>		
Address	<input type="text"/>	City	<input type="text"/>	State	<input type="text"/>
		Zip	<input type="text"/>		
E-mail address	<input type="text"/>				
Telephone No.*	<input type="text"/>				
Fax No.* (Please provide fax number for PA response notification.)	<input type="text"/>				

* Required

Please also complete for professionally administered medications, if applicable.

Start date	<input type="text"/>	End date	<input type="text"/>		
Servicing prescriber/facility name	<input type="text"/>	<input type="checkbox"/>	Same as prescribing provider		
Servicing provider/facility address	<input type="text"/>				
Servicing provider NPI/tax ID No.	<input type="text"/>				
Name of billing provider	<input type="text"/>				
Billing provider NPI No.	<input type="text"/>				
Is this a request for recertification?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
CPT code	<input type="text"/>	No. of visits	<input type="text"/>	J code	<input type="text"/>
		No. of units	<input type="text"/>		

Provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am either the prescribing provider or duly authorized to act on behalf of the provider identified in the Prescriber information section of this form. Any attached statement on 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.

Signature of provider or individual duly authorized to act on behalf of the provider:

Printed legal name and title of signatory above

<input type="text"/>	Date	<input type="text"/>
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(The form can either be signed by hand and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.)