



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

Antihistamine 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.

Medication information

Medication requested (Check one or all that apply.)

Intranasal Antihistamines

azelastine 0.15% nasal spray

olopatadine nasal spray

Single Oral Antihistamines

carbinoxamine 6 mg tablet

desloratadine orally disintegrating tablet (ODT)

carbinoxamine extended-release

dexchlorpheniramine solution

carbinoxamine solution

levocetirizine solution

clemastine syrup

Combination Oral Antihistamines

Clarinex-D (desloratadine/pseudoephedrine)

Suppository Antihistamines

promethazine suppository

Dose and frequency of medication requested

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

Allergic conjunctivitis

Non-allergic rhinitis

Allergic rhinitis

Urticaria

Motion sickness

Other

Nausea/Vomiting

Please list all other medications currently prescribed for the member for this indication.

Section I. Please complete for desloratadine ODT and levocetirizine solution requests.

1. Please provide medical necessity for requested formulation (e.g., member utilizes a feeding tube, has a swallowing disorder or condition affecting ability to swallow, is < 13 years of age).

2. Has the member had a trial with cetirizine syrup and loratadine solution?

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

No. Please explain why cetirizine syrup and loratadine solution are not appropriate for this member.

Section II. Please complete for Clarinex-D requests.

1. Has the member had a trial with an intranasal corticosteroid?

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

No. Please describe why intranasal corticosteroids are not appropriate for this member.

2. Has the member had a trial with two of the following: cetirizine/pseudoephedrine, loratadine/pseudoephedrine, fexofenadine/pseudoephedrine?

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

No. Please describe why cetirizine/pseudoephedrine, loratadine/pseudoephedrine, and fexofenadine/pseudoephedrine are not appropriate for this member.

Section III. Please complete for azelastine 0.15% nasal spray and olopatadine nasal spray requests.

1. Has the member had a trial with two of the following: an intranasal corticosteroid, azelastine 137 mcg nasal spray, or azelastine/fluticasone propionate?

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

No. Please describe why intranasal corticosteroids, azelastine 137 mcg nasal spray, and azelastine/fluticasone propionate are not appropriate for this member.

2. For requests for any agent at a quantity > 1 inhaler/30 days, please document an inadequate response to the manufacturer's recommended dosing.

Section IV. Please complete for carbinoxamine 6 mg tablet, carbinoxamine extended-release, and carbinoxamine solution requests.

1. Has the member had a trial with an intranasal corticosteroid and two non-selective antihistamines?

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

No. Please describe why intranasal corticosteroids and non-selective antihistamines are not appropriate for this member.

2. For carbinoxamine 6 mg tablet requests, has the member had a trial with carbinoxamine 4 mg tablet?

Yes. Please list the dates/duration of trials and outcomes in Section VII below.*

No. Please describe why carbinoxamine 4 mg tablet is not appropriate for this member.

3. For carbinoxamine extended-release and carbinoxamine solution requests, please provide medical necessity for requested formulation (e.g., member utilizes a feeding tube, has a swallowing disorder or condition affecting ability to swallow, is < 13 years of age).

4. For carbinoxamine extended-release requests, has the member had a trial with carbinoxamine immediate-release solution?

Yes. Please list the dates/duration of trials and outcomes in Section VII below.*

No. Please describe why carbinoxamine immediate-release solution is not appropriate for this member.

Section V. Please complete for clemastine syrup and dexchlorpheniramine solution requests.

1. Please provide medical necessity for requested formulation (e.g., member utilizes a feeding tube, has a swallowing disorder or condition affecting ability to swallow, is < 13 years of age).

2. Has the member had a trial with cetirizine syrup, fexofenadine suspension, and loratadine solution?
 Yes. Please list the drug names, dates/duration of trials, and outcomes in Section VII below.*
 No. Please explain why cetirizine syrup, fexofenadine suspension, and loratadine solution are not appropriate for this member.

Section VI. Please complete for promethazine suppository requests.

Please provide medical necessity for the requested formulation as noted by nausea or vomiting with oral formulations.

Section VII. Please complete for all requests as needed.

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

Drug name 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.

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Drug name 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.

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

Section VIII. 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 health care 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.)