



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

Headache Therapy (Ergot Alkaloids and Serotonin Receptor 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

Ergot Alkaloids

- | | |
|--------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> dihydroergotamine injection | <input type="checkbox"/> ergotamine |
| <input type="checkbox"/> dihydroergotamine nasal spray | <input type="checkbox"/> ergotamine/caffeine suppository |

Serotonin Receptor Agents

- | | |
|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| <input type="checkbox"/> almotriptan | <input type="checkbox"/> sumatriptan 5 mg, 20 mg nasal spray < 6 years of age |
| <input type="checkbox"/> eletriptan | <input type="checkbox"/> sumatriptan tablet > quantity limits |
| <input type="checkbox"/> frovatriptan | <input type="checkbox"/> sumatriptan/naproxen |
| <input type="checkbox"/> naratriptan > quantity limits | <input type="checkbox"/> Symbravo (rizatriptan/meloxicam) |
| <input type="checkbox"/> Reyvow (lasmiditan) | <input type="checkbox"/> Tosymra (sumatriptan 10 mg nasal spray) |
| <input type="checkbox"/> rizatriptan orally disintegrating tablet > quantity limits | <input type="checkbox"/> Zembrace (sumatriptan injection) |
| <input type="checkbox"/> rizatriptan tablet > quantity limits | <input type="checkbox"/> zolmitriptan nasal spray |
| <input type="checkbox"/> sumatriptan injection | <input type="checkbox"/> zolmitriptan orally disintegrating tablet |
| <input type="checkbox"/> sumatriptan 5 mg, 20 mg nasal spray > quantity limits | <input type="checkbox"/> zolmitriptan tablet > quantity limits |
| <input type="checkbox"/> Other* <input type="text"/> | |

**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).*

Quantity requested per 30 days

Dose, frequency, and duration of requested drug

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

- Cluster headache. Frequency of headaches (number/30 days)
- Migraine headache. Frequency of migraine attacks (number/30 days)
- Other. Specify pertinent medical history, diagnostic studies, and/or laboratory tests.
-

Section I. Please complete for ergotamine and all serotonin receptor agent requests, excluding generic naratriptan, rizatriptan orally disintegrating tablet, rizatriptan tablets, sumatriptan 5 mg, 20 mg nasal spray, sumatriptan tablets, and zolmitriptan tablets. Please note, this section must be completed for brand name Imitrex tablet, Maxalt MLT, Maxalt tablet, or Zomig tablet requests.

1. Has the member tried sumatriptan tablets?

- Yes. Please describe the outcome. Adverse reaction Inadequate response Other
Briefly describe the details of adverse reaction, inadequate response, or other.

- No. Explain why sumatriptan tablets are not appropriate for this member.

2. Has the member tried rizatriptan?

- Yes. Please describe the outcome. Adverse reaction Inadequate response Other
Briefly describe the details of adverse reaction, inadequate response, or other.

- No. Explain why rizatriptan is not appropriate for this member.

3. Has the member tried zolmitriptan tablets?

- Yes. Please describe the outcome. Adverse reaction Inadequate response Other
Briefly describe the details of adverse reaction, inadequate response, or other.

- No. Explain why zolmitriptan tablets are not appropriate for this member.

4. Has the member tried naratriptan tablets?

- Yes. Please describe the outcome. Adverse reaction Inadequate response Other
Briefly describe the details of adverse reaction, inadequate response, or other.

- No. Explain why naratriptan tablets are not appropriate for this member.

5. For Symbravo, please describe the medical necessity for use of the combination product instead of the commercially available separate agents.

Section II. Please complete for all serotonin receptor agent requests for quantities above quantity limits.

1. Is the member under the care of a neurologist? Yes No

2. Is the member currently receiving prophylaxis?

- Yes. Please specify.

Drug

Dose and frequency

Drug

Dose and frequency

- No. Explain why prophylaxis is not appropriate for this member.

Section III. Please complete for requests for sumatriptan 5 mg, 20 mg nasal spray for members < 6 years of age

1. Is the member under the care of a neurologist? Yes No
2. Has the member tried acetaminophen?
 Yes. Please describe the outcome. Adverse reaction Inadequate response Other
Briefly describe the details of adverse reaction, inadequate response, or other.

- No. Explain why acetaminophen is not appropriate for this member.

3. Has the member tried a nonsteroidal anti-inflammatory drug?
 Yes. Please describe the outcome. Adverse reaction Inadequate response Other
Briefly describe the details of adverse reaction, inadequate response, or other.

- No. Explain why a nonsteroidal anti-inflammatory drug is not appropriate for this member.

Section IV. Please complete for requests for sumatriptan injection, Tosymra, Zembrace, zolmitriptan nasal spray and zolmitriptan orally disintegrating tablets.

1. Please describe medical necessity for the use of the requested dosage formulation instead of tablet formulation.

2. For Tosymra requests, has the member had a trial with zolmitriptan or sumatriptan 5 mg, 20 mg nasal spray?

- Yes. Please describe the outcome. Adverse reaction Inadequate response Other
Briefly describe the details of adverse reaction, inadequate response, or other.

- No. Explain why zolmitriptan or sumatriptan 5 mg, 20 mg nasal spray is not appropriate for this member.

3. For Zembrace requests, has the member had a trial with sumatriptan injection?

- Yes. Please describe the outcome. Adverse reaction Inadequate response Other
Briefly describe the details of adverse reaction, inadequate response, or other.

- No. Explain why sumatriptan injection is not appropriate for this member.

Section V. Please complete for requests for sumatriptan/naproxen.

Please describe medical necessity for the use of the combination product (sumatriptan/naproxen) instead of the commercially available separate agents.

Section VI. Please complete for requests for Reyvow.

1. Is the member under the care of a neurologist? Yes No

2. Has the member had a trial with two different triptan agents?

Yes. Please describe the drug names and outcomes.

Drug name Adverse reaction Inadequate response

Briefly describe the details of adverse reaction or inadequate response.

Drug name Adverse reaction Inadequate response

Briefly describe the details of adverse reaction or inadequate response.

No. Explain why triptan agents are not appropriate for this member.

Section VII. Please complete for dihydroergotamine nasal spray requests.

1. Has the member tried sumatriptan nasal spray?

Yes. Please describe the outcome. Adverse reaction Inadequate response Other

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

No. Explain why sumatriptan nasal spray is not appropriate in this member.

2. Has the member tried zolmitriptan nasal spray?

Yes. Please describe the outcome. Adverse reaction Inadequate response Other

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

No. Explain why zolmitriptan nasal spray is not appropriate in this member.

Section VIII. Please complete for dihydroergotamine injection and ergotamine/caffeine suppository requests.

1. Please describe medical necessity for the use of the requested dosage formulation.

2. For dihydroergotamine injection requests, has the member tried sumatriptan injection?

Yes. Please describe the outcome. Adverse reaction Inadequate response Other

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

No. Explain why sumatriptan injection is not appropriate in this member.

3. For ergotamine/caffeine suppository requests, has the member tried sumatriptan nasal spray?

Yes. Please describe the outcome. Adverse reaction Inadequate response Other

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

No. Explain why sumatriptan nasal spray is not appropriate in this member.

Section IX. 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.)