



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

Hepatitis Antiviral 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.

Diagnosis

- Hepatitis C
 Acute Chronic
- HIV-coinfection Renal impairment. Creatinine clearance Status post-liver transplant
- HCV Genotype 1a 1b 2 3 4 5 6 Other
- Treatment-experienced (Please complete the section for Prior Hepatitis Treatment.) Treatment-naïve
- Treatment initiation Anticipated start date Anticipated end date
- Continuation of therapy, current week
- Chronic Hepatitis B

Fibrosis Staging

Please indicate below and attach documentation including medical records and results of diagnostic tests assessing liver disease staging (e.g., APRI, Fibroscan, Fibrosure, FIB-4). Staging information must clearly demonstrate early stage (Metavir Score F0 to F2) or advance liver disease (Metavir Score F3 to F4). If results are inconclusive or if imaging studies are performed and are not suggestive of cirrhosis, further diagnostic testing may be required.

- Metavir Score F0 to F2 Metavir Score F3 to F4 Other

Does the member have cirrhosis? Yes No

If yes, please indicate Child-Turcotte-Pugh (CTP) class. (Please attach calculations.) A B C

Lab Values

Baseline HCV RNA lab value

Date drawn

Prior Hepatitis Treatment

Drug name Dates/duration of use

Please indicate treatment outcome. Adverse reaction Null responder Partial responder
 Relapser Other

Briefly describe details.

Drug name Dates/duration of use

Please indicate treatment outcome. Adverse reaction Null responder Partial responder
 Relapser Other

Briefly describe details.

Drug name Dates/duration of use

Please indicate treatment outcome. Adverse reaction Null responder Partial responder
 Relapser Other

Briefly describe details.

Complete Treatment Regimen (Check All that Apply)

HCV Combination Agents

- ledipasvir/sofosbuvir Vosevi (sofosbuvir/velpatasvir/voxilaprevir)
 Mavyret (glecaprevir/pibrentasvir) Zepatier (elbasvir/grazoprevir)
 sofosbuvir/velpatasvir

Dose/frequency Duration of therapy

For sofosbuvir/velpatasvir requests only, for members with HCV genotype 3 who are treatment-experienced without cirrhosis, please indicate if NS5A resistance-associated substitution Y93H is present. (Please attach laboratory testing results.) Yes No

For Zepatier requests only, for members with HCV genotype 1a, please indicate if baseline NS5A polymorphisms at amino acid positions 28, 30, 31 or 93 are present. (Please attach laboratory testing results.) Yes No

HCV Single Agents

- Sovaldi (sofosbuvir)

Dose/frequency Duration of therapy

Pegylated Interferon

- Pegasys (peginterferon alfa-2a)

Dose/frequency Duration of therapy

Ribavirin

- ribavirin 200 mg capsule
 None. Please explain the clinical rationale for not using ribavirin below.

Dose/frequency Duration of therapy

Please indicate if using ribavirin 200 mg tablets. Yes No

Please describe medical necessity for use of the other products instead of the 200 mg tablet.

If applicable, please explain the clinical rationale for not using ribavirin.

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.)