



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

Oral/Injectable Antifungal 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

- | | | |
|--|--|---|
| <input type="checkbox"/> Brexafemme (ibrexafungerp) | <input type="checkbox"/> Oravig (miconazole buccal tablet) | <input type="checkbox"/> Tolsura (itraconazole 65 mg capsule) |
| <input type="checkbox"/> Cresemba (isavuconazonium)* | <input type="checkbox"/> posaconazole injection* | <input type="checkbox"/> Vivjoa (oteseconazole) |
| <input type="checkbox"/> Noxafil (posaconazole powder for oral suspension) * | <input type="checkbox"/> posaconazole suspension* | <input type="checkbox"/> voriconazole suspension* |
| | <input type="checkbox"/> Rezzayo (rezafungin) | <input type="checkbox"/> Other** <input type="text"/> |

*For Cresemba IV, posaconazole, and voriconazole suspension Section VIII is also required.

**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).

Dose and frequency of medication requested

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

***voriconazole requests only **Cresemba and posaconazole**

- | | | |
|--|---|--|
| <input type="checkbox"/> <i>Aspergillus</i> endophthalmitis* | <input type="checkbox"/> <i>Scedosporium</i> infection* | <input type="checkbox"/> <i>Fusarium</i> infection* |
| <input type="checkbox"/> <i>Aspergillus</i> keratitis* | <input type="checkbox"/> <i>Aspergillus</i> infection | <input type="checkbox"/> <i>Zygomycosis</i> (mucormycosis)** |

Please note: For posaconazole or voriconazole for the above indications, Sections I through VIII are not required.

For all indications checked below, please complete sections in parentheses

- | | | |
|--|---|--|
| <input type="checkbox"/> Blastomycosis (Section V) | <input type="checkbox"/> Invasive candidiasis (Section X) | <input type="checkbox"/> Vulvovaginal candidiasis (Section IX) |
| <input type="checkbox"/> Candidemia (Section II)† | <input type="checkbox"/> Onychomycosis (Section V) | <input type="checkbox"/> Other <input type="text"/> |
| <input type="checkbox"/> Disseminated candidiasis (Section II) | <input type="checkbox"/> Oropharyngeal candidiasis (Section IV) | (Please attach a letter regarding medical necessity.) |
| <input type="checkbox"/> Esophageal candidiasis (Section III) | <input type="checkbox"/> Prevention of <i>Aspergillus</i> and <i>Candida</i> infections (Section I) | |
| <input type="checkbox"/> Histoplasmosis (Section V) | | |

† For Rezzayo, please complete Section X

Section I. Please complete for posaconazole and voriconazole suspension for prevention of Aspergillus and Candida infections.

1. Does the member have one of the following?

- Graft-versus-host disease Hematopoietic stem cell transplantation
 Hematologic malignancy and neutropenic Hematologic malignancy and undergoing chemotherapy
 No. Please describe why the member requires antifungal prophylaxis.

2. For posaconazole powder for oral suspension requests, is the member's weight ≤ 40 kg?

- Yes No. Please provide clinical rationale for use in non-FDA-approved weight.

3. For posaconazole requests, is the member's age within the FDA-approved range for use (posaconazole suspension ≥ 13 years; posaconazole powder for oral suspension ≥ 2 years to < 18 years; posaconazole IV ≥ 2 years)?

- Yes No. Please provide clinical rationale for use in non-FDA-approved age.

Section II. Please complete for voriconazole suspension for candidemia and disseminated candidiasis.

Has the member had a trial of oral fluconazole?

- Yes. Dates/durations of use

Did the member experience any of the following? Adverse reaction Inadequate response
Briefly describe details of adverse reaction or inadequate response.

- No. Please describe why the member is not a candidate for oral fluconazole.

Section III. Please complete for posaconazole suspension and voriconazole suspension for esophageal candidiasis.

1. Has the member had a trial of fluconazole?

- Yes. 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.

- No. Please describe why the member is not a candidate for fluconazole.

2. Has the member had a trial of itraconazole?

- Yes. 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.

- No. Please describe why the member is not a candidate for itraconazole.

3. For posaconazole requests, is the member 13 years of age or older?
 Yes No. Please provide clinical rationale for use in non-FDA-approved age.
4. For posaconazole requests, has the member had a trial of voriconazole?
 Yes. 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.
- No. Please describe why the member is not a candidate for voriconazole.

Section IV. Please complete for Oravig for oropharyngeal candidiasis.

1. Has the member had a trial of clotrimazole troches?
 Yes. 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.
- No. Please describe why the member is not a candidate for clotrimazole troches.
2. Has the member had a trial of nystatin suspension or tablet?
 Yes. 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.
- No. Please describe why the member is not a candidate for nystatin suspension and tablet.
3. Has the member had a trial of fluconazole suspension or tablet?
 Yes. 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.
- No. Please describe why the member is not a candidate for fluconazole suspension and tablet.

Section V. Please complete for posaconazole suspension and voriconazole for oropharyngeal candidiasis.

1. Has the member had a trial of oral fluconazole?
 Yes. 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.
- No. Please describe why the member is not a candidate for oral fluconazole.

2. Has the member had a trial of itraconazole?

Yes. 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.

No. Please describe why the member is not a candidate for itraconazole.

3. For posaconazole requests, is the member 13 years of age or older?

Yes No. Please provide clinical rationale for use in non-FDA-approved age.

4. For voriconazole requests, has the member had a trial of posaconazole?

Yes. 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.

No. Please describe why the member is not a candidate for posaconazole.

Section VI. Please complete for Tolsura.

Please provide medical necessity for the requested formulation instead of itraconazole 100 mg capsules and itraconazole oral suspension.

Section VII. Please complete for Cresemba for the treatment of Aspergillus infection.

1. Member's current weight Date

2. Has the member had a trial of voriconazole?

Yes. 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.

No. Please describe why the member is not a candidate for voriconazole.

3. Has the member had a trial of posaconazole?

Yes. 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.

No. Please describe why the member is not a candidate for posaconazole.

Section VIII. Please complete for Cresemba IV, posaconazole IV, posaconazole powder for oral suspension, posaconazole suspension and voriconazole suspension.

1. Please provide medical necessity for use of the requested formulation.

Section IX. Please complete for Cresemba for Zygomycosis (mucormycosis).

1. Member's current weight Date
2. Has the member had a trial of posaconazole?

Yes. 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.

No. Please describe why the member is not a candidate for posaconazole.

Section X. Please complete for Brexafemme and Vivjoa for vulvovaginal candidiasis (VVC).

For Brexafemme requests for a diagnosis of acute VVC, please complete questions 1 and 2. For Brexafemme requests for a diagnosis of recurrent VVC, please complete questions 1 through 5. For Vivjoa requests, please complete questions 1 through 6.

1. Has the member had a trial of oral fluconazole?

Yes. 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.

No. Please describe why the member is not a candidate for oral fluconazole.

2. Is the member post-menarchal? Yes No
3. Please attach results from a diagnostic test to confirm diagnosis (e.g, KOH, nucleic acid probe-based test system, nucleic acid amplification, etc.).
4. Has the member had \geq three acute VVC episodes within past 12 months? Yes No
5. Is the member not of reproductive potential? Yes No
6. Is the member post-menopausal? Yes No

Section XI. Please complete for Rezzayo.

1. Has the member had a trial of Eraxis?

Yes. 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.

No. Please describe why the member is not a candidate for Eraxis.

2. Has the member had a trial of caspofungin?

Yes. 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.

No. Please describe why the member is not a candidate for caspofungin.

3. Has the member had a trial of micafungin?

Yes. 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.

No. Please describe why the member is not a candidate for micafungin.

Section XII. 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

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

Date

(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.)