



# 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](http://go.covermy meds.com/OptumRx)  
Online Prior Authorization: [providerportal.surescripts.net/ProviderPortal/optum](http://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](http://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](http://go.covermy meds.com/OptumRx)  
Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555  
Online Prior Authorization (Medical Specialty Reviews): [provider.massgeneralbrighamhealthplan.org](http://provider.massgeneralbrighamhealthplan.org)  
Medical Specialty Reviews: Fax: (888) 656-6671 - Tel: (833) 895-2611

**Tufts Health Plan**  
Online Prior Authorization: [point32health.promptpa.com](http://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](http://wellsense.org/providers/ma/pharmacy/prior-authorizations)  
Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822

# Ophthalmic Anti-Allergy and Anti-Inflammatory 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](http://www.mass.gov/druglist).

### Medication information

#### Medication requested

##### Ophthalmic Anti-Allergy Agents

- epinastine (Section VII)
- Zerviate (cetirizine ophthalmic solution) (Section I)

##### Ophthalmic Corticosteroids (Section III)

- Eysuvis (loteprednol 0.25% suspension)
- Inveltys (loteprednol 1% suspension)
- Lotemax SM (loteprednol 0.38% gel)

##### Ophthalmic Non-Steroidal Anti-Inflammatory Agents (Section II)

- bromfenac 0.075%
- Ilevro (nepafenac 0.3% ophthalmic solution)

##### Other Medication

- Other\*

*\*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, frequency, and duration of medication requested

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

- Allergic conjunctivitis (seasonal or perennial)
- Demodex Blepharitis
- Keratoconjunctivitis sicca
- Post-operative pain and/or inflammation following ocular surgery
- Vernal conjunctivitis and/or vernal keratitis
- Other (Please indicate.)

##### Symptoms and symptom frequency

**Section I. Please complete for Zerviate requests.**

For members  $\geq$  two to  $<$  three years of age, please complete question 1. For members  $\geq$  three years of age, please complete question 2. For members with diagnosis of vernal keratoconjunctivitis or atopic keratoconjunctivitis please complete question 3 if member is  $\geq$  two to  $<$  three years of age, and question 4 if member is  $\geq$  three years of age.

1. Has the member had a trial with two of the following: alcaftadine, Alomide, bepotastine, epinastine, or olopatadine ophthalmic solution?

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

Drug name  Dates/duration of trial

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

Drug name  Dates/duration of trial

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 explain if there is a contraindication to these trials.

2. Has the member had a trial with two of the following: alcaftadine, Alomide, azelastine ophthalmic solution, bepotastine, epinastine, ketotifen, or olopatadine ophthalmic solution?

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

Drug name  Dates/duration of trial

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

Drug name  Dates/duration of trial

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 explain if there is a contraindication to these trials.

3. Has the member had a trial with one of the following: azelastine ophthalmic solution, bepotastine, epinastine, or olopatadine ophthalmic solution?

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

Drug name  Dates/duration of trial

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 explain if there is a contraindication to these trials.

4. Has the member had a trial with one of the following: azelastine ophthalmic solution, epinastine, ketotifen, or olopatadine ophthalmic solution?

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

Drug name  Dates/duration of trial

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 explain if there is a contraindication to these trials.

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**Section II. Please complete for all requests for ophthalmic non-steroidal anti-inflammatory agents.**

1. For bromfenac 0.075% ophthalmic solution requests, has the member had a trial with bromfenac 0.07% or 0.09% ophthalmic solution?

Yes. Please list the drug name, dates/duration of trials, and outcomes below.\*

Drug name

Dates/duration of trial

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 explain if there is a contraindication to these trials.

2. For Ilevro requests, has the member had a trial with nepafenac 0.1% ophthalmic suspension?

Yes. Please list the dates/duration of trials and outcomes. Dates/duration of trial

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 explain if there is a contraindication to nepafenac 0.1% ophthalmic suspension.

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**Section III. Please complete for all requests for ophthalmic corticosteroids.**

1. For Eysuvis requests, has the member had a trial with a topical corticosteroid for ophthalmic use that is available without prior authorization?

Yes. Please list the drug name, dates/duration of trials, and outcomes below.\*

Drug name

Dates/duration of trial

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 explain if there is a contraindication to this trial.

2. For Eysuvis requests, has the member had a trial with cyclosporine 0.05% ophthalmic emulsion?

Yes. Please list the dates/duration of trials and outcomes.\* Dates/duration of trial

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 explain if there is a contraindication to this trial.

3. For Inveltys and Lotemax SM, has the member had a trial with loteprednol 0.5% suspension, gel or ointment?

Yes. Please list the dates/duration of trials and outcomes.\* Dates/duration of trial

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 explain if there is a contraindication to this trial.

4. For Inveltys and Lotemax SM, has the member had a trial with fluorometholone?

Yes. Please list the dates/duration of trials and outcomes.\* Dates/duration of trial

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 explain if there is a contraindication to this trial.

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**Section IV. Please complete for all requests for Cequa, Miebo, Restasis Multidose, Tryptyr, Tyrvaya, and Xiidra.**

1. Has the member had a trial with cyclosporine 0.05% ophthalmic emulsion?

Yes. Please list the dates/duration of trials and outcomes.\* Dates/duration of trial

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 explain if there is a contraindication to this trial.

2. For Restasis Multidose requests, please provide medical necessity for the use of the requested formulation instead of cyclosporine 0.05% ophthalmic emulsion (single use vial formulation).

3. For Miebo and Tyrvaya requests, has the member had a trial with Xiidra?

Yes. Please list the dates/duration of trials and outcomes.\* Dates/duration of trial

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 explain if there is a contraindication to this trial.

4. For Tryptyr requests, has the member had a trial with Miebo or Tyrvaya?

Yes. Please list the drug name, dates/duration of trials, and outcomes below.\*

Drug name

Dates/duration of trial

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 explain if there is a contraindication to these trials.

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**Section V. Please complete for all requests for Verkazia.**

1. Has the member had a trial with ophthalmic azelastine, epinastine, ketotifen, or olopatadine?

Yes. Please list the drug name, dates/duration of trials, and outcomes below.\*

Drug name  Dates/duration of trial

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 explain if there is a contraindication to these trials.

2. Has the member had a trial with a topical corticosteroid for ophthalmic use?

Yes. Please list the drug name, dates/duration of trials, and outcomes below.\*

Drug name  Dates/duration of trial

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 explain if there is a contraindication to this trial.

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### Section VI. Please complete for all requests for Vevye.

1. Has the member had a trial with ophthalmic cyclosporine 0.05% emulsion?

Yes. Please list dates/duration of use and outcomes below.\*

Dates/duration of trial  Outcome

No. Please document if there is a contraindication to ophthalmic cyclosporine 0.05% emulsion.

2. Has the member had a trial with ophthalmic cyclosporine 0.09% emulsion?

Yes. Please list dates/duration of use and outcomes below.\*

Dates/duration of trial  Outcome

No. Please document if there is a contraindication to ophthalmic cyclosporine 0.09% emulsion.

3. Has the member had a trial with Tyrvaya?

Yes. Please list dates/duration of use and outcomes below.\*

Dates/duration of trial  Outcome

No. Please document if there is a contraindication to Tyrvaya.

4. Has the member had a trial with Xiidra?

Yes. Please list dates/duration of use and outcomes below.\*

Dates/duration of trial  Outcome

No. Please document if there is a contraindication to Xiidra.

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### Section VII. Please complete for epinastine requests.

For members  $\geq$  two to  $<$  three years of age, please complete question 1. For members  $\geq$  three years of age, please complete question 2.

1. Has the member had a trial with two of the following: bepotastine, ketoprofen, or olopatadine ophthalmic solution?

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

Drug name  Dates/duration of trial

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

Drug name  Dates/duration of trial

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 explain if there is a contraindication to these trials.

2. Has the member had a trial with two of the following: alcaftadine, Alomide, azelastine ophthalmic solution, bepotastine, ketotifen, or olopatadine ophthalmic solution?

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

Drug name  Dates/duration of trial

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

Drug name  Dates/duration of trial

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 explain if there is a contraindication to these trials.

\* Please attach a letter with additional information regarding medication trials as applicable.

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### 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

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**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"/>
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.)