



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

Immune Globulin 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"/> Alyglo | <input type="checkbox"/> Flebogamma | <input type="checkbox"/> Gammaplex | <input type="checkbox"/> Panzyga |
| <input type="checkbox"/> Asceniv | <input type="checkbox"/> Gamastan S/D | <input type="checkbox"/> Gamunex-C | <input type="checkbox"/> Privigen |
| <input type="checkbox"/> Bivigam | <input type="checkbox"/> Gammagard | <input type="checkbox"/> Hizentra | <input type="checkbox"/> Xembify |
| <input type="checkbox"/> Cutaquig | <input type="checkbox"/> Gammagard S/D | <input type="checkbox"/> Hyqvia | |
| <input type="checkbox"/> Cuvitru | <input type="checkbox"/> Gammaked | <input type="checkbox"/> Octagam | |

Dose of medication requested mg per kg = g

Frequency and duration of medication requested

Please specify dosing schedule. Scheduled Intermittent

Member's current actual body weight (ABW) Date

Member's current height Date

Member's current Body Mass Index (BMI) Date

For initiation of intravenous immune globulin (IVIG), if a member's BMI is $\geq 30 \text{ kg/m}^2$ or ABW is $> 120\%$ of ideal body weight (IBW), dosing calculated using adjusted body weight has been demonstrated to have similar clinical effect as using ABW. MassHealth suggests the use of this dosing strategy to promote cost effective care. This is not meant to replace clinical decision making when initiating medication therapy.

Please complete the below question.

If member meets the criteria noted above (BMI $\geq 30 \text{ kg/m}^2$ or ABW $> 120\%$ of IBW), is the member a candidate for adjusted body weight dosing? If criteria are not applicable, this may be left blank.

Yes. MassHealth to calculate total dose based on adjusted body weight* (may round dose to vial size).

No. Please explain why adjusted body weight* dosing is not appropriate for this member.

* *Adjusted Body Weight = IBW + 0.4 (ABW - IBW)*

Please indicate billing preference. Pharmacy Prescriber in-office Hospital outpatient

If applicable, please also complete section for professionally administered medications at end of form.

Drug NDC (if known) or service code

Indication or ICD-10 code, if applicable

Is the member stabilized on the requested medication? Yes. Please provide start date. No

over

Is the prescriber a specialist in the treatment of the requested indication?

- Yes. Please indicate prescriber specialty.
- No. Please attach consultation notes from a specialist in the treatment of the requested indication (e.g., cardiologist, hematologist, immunologist, neurologist, oncologist, rheumatologist).

Section I. Please specify the indication for all requests except for a diagnosis of dermatomyositis (DM). For Asceniv requests, please also complete Section III as appropriate.

- Primary immunodeficiency disorders (PID)
Please attach laboratory documentation supporting diagnosis.
Provide date and results of most recent serum immunoglobulin levels (including laboratory reference ranges).

- Immune thrombocytopenia (ITP)
Provide date and results of most recent platelet count (including laboratory reference ranges).

Does the member have clinically significant bleeding? Yes. Please describe below. No

Does the member have a history of or risk of significant bleeding? Yes. Please describe below. No

Does the member have a medical necessity to raise platelet count within 12 to 24 hours?
 Yes. Please describe below. No

- Kawasaki disease (mucocutaneous lymph node syndrome)

Provide date of onset.

Does the member have an unexplained persistent fever? Yes No

Does the member have evidence of aneurysm? Yes No

Does the member exhibit signs of persistent inflammation? Yes No

- B-cell chronic lymphocytic leukemia (CLL)
- Chronic inflammatory demyelinating polyneuropathy (CIDP)
- Multifocal motor neuropathy (MMN)
- Other

Please describe the medical necessity for the use of immune globulin including previous trials and outcomes.

Section II. Please complete for treatment of dermatomyositis (DM). For Asceniv requests, please also complete Section III as appropriate.

1. Has the member had a trial with one systemic corticosteroid?
 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.
- 2. Does the member have severe disease? Yes No
- 3. Has the member had a trial with one of the following: azathioprine, chloroquine, hydroxychloroquine, methotrexate, mycophenolate mofetil, or rituximab?
 - Yes. Please list the drug names, dates/duration of trials and outcomes below.*

Drug name <input style="width: 150px;" type="text"/>	Dates/duration of trial <input style="width: 150px;" type="text"/>
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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.
 - No. Please explain if there is a contraindication to these trials.

Section III. Please also complete for requests for Asceniv. Please complete Section I or II above as appropriate.

Please provide clinical rationale for the use of this product instead of other available IVIG products.

Section IV. 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 <input style="width: 150px;" type="text"/>	Dates/duration of use <input style="width: 150px;" type="text"/>
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 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"/>
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.)