



# 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

# Intranasal Corticosteroids 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

- |  |   |
|--|---|
| <input type="checkbox"/> flunisolide nasal spray                                       | <input type="checkbox"/> Qnasl (beclomethasone nasal aerosol)                           |
| <input type="checkbox"/> fluticasone propionate 50 mcg nasal spray > 1 inhaler/30 days | <input type="checkbox"/> Ryaltris (olopatadine/mometasone)                              |
| <input type="checkbox"/> mometasone nasal spray  | <input type="checkbox"/> Sinuva (mometasone sinus implant)                              |
| <input type="checkbox"/> Omnaris (ciclesonide 50 mcg nasal spray) > 1 inhaler/30 days  | <input type="checkbox"/> Xhance (fluticasone propionate 93 mcg nasal spray)             |
|  | <input type="checkbox"/> Zetonna (ciclesonide 37 mcg nasal aerosol) > 1 inhaler/30 days |

### Dose, frequency, and duration of medication requested

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Allergic rhinitis | <input type="checkbox"/> Nasal polyps with a history of ethmoid sinus surgery | <input type="checkbox"/> Seasonal allergic rhinitis |
| <input type="checkbox"/> Nasal polyps      | <input type="checkbox"/> Non-allergic rhinitis                                | <input type="checkbox"/> Other (please indicate)    |

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

## Section I. Please complete for requests for flunisolide nasal spray, mometasone nasal spray, and Qnasl.

For members  $\geq 6$  years of age, please complete questions 1 through 3. For members  $\geq 4$  to  $< 6$  years of age, please complete questions 1 and 3. For members  $< 4$  years of age, please complete question 3.

1. Has the member had a trial with fluticasone propionate 50 mcg nasal spray?

- Yes. Please list the dates/duration of trials, and outcomes.\* Dates/duration of use
- Did the member experience any of the following?  Adverse reaction  Inadequate response  Other
- Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

- No. Please describe clinical rationale for not using fluticasone propionate 50 mcg nasal spray.

2. Has the member had a trial with budesonide over-the-counter (OTC) nasal spray?

Yes. Please list the dates/duration of trials, and outcomes.\* Dates/duration of use   
Did the member experience any of the following?  Adverse reaction  Inadequate response  Other  
Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

No. Please describe clinical rationale for not using budesonide OTC nasal spray.

3. Has the member had a trial with triamcinolone OTC nasal spray?

Yes. Please list the dates/duration of trials, and outcomes.\* Dates/duration of use   
Did the member experience any of the following?  Adverse reaction  Inadequate response  Other  
Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

No. Please describe clinical rationale for not using triamcinolone OTC nasal spray.

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**Section II. Please complete for any agent at a quantity > one inhaler per 30 days. Please complete Section I above as appropriate.**

1. Has the member had a trial with two intranasal or second-generation oral antihistamines?

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

Drug name  Dates/duration of use

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

Drug name  Dates/duration of use

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

No. Please describe clinical rationale for not using intranasal or second-generation oral antihistamines.

2. Has the member had an inadequate response to the manufacturer's recommended dosing?

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

Drug name  Dose and frequency  Dates/duration of use

Briefly describe details of inadequate response or other.

No. Please describe clinical rationale for not using the requested agent at the manufacturer's recommended dosing.

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**Section III. Please complete for requests for Ryaltris.**

1. Has the member had a trial with one intranasal corticosteroid agent used in combination with one intranasal antihistamine agent?

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

Drug name  Dates/duration of use

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

Drug name  Dates/duration of use

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

No. Please describe clinical rationale for not using intranasal corticosteroids in combination with intranasal antihistamines.

2. Has the member had a trial with azelastine/fluticasone propionate nasal spray?

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

Dates/duration of use

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

No. Please describe clinical rationale for not using azelastine/fluticasone propionate nasal spray.

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**Section IV. Please complete for requests for Sinuva.**

1. Please indicate prescriber specialty below.

Otolaryngologist  Other

2. Has the member had a trial with two intranasal corticosteroids?

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

Drug name  Dates/duration of use

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

Drug name  Dates/duration of use

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

No. Please describe clinical rationale for not using intranasal corticosteroids.

3. Has the member had a trial with an oral corticosteroid?

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

Drug name  Dates/duration of use

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

No. Please describe clinical rationale for not using an oral corticosteroid.

*\*Please attach a letter documenting additional trials as necessary.*

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### Section V. Please complete for requests for Xhance.

Please describe medical necessity for use of the requested agent instead of all other intranasal corticosteroids.

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### Section VI. 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

<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.)