



# 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.

<b>MassHealth Fee-For-Service (FFS) Plan, Primary Care Clinician (PCC) Plan, Primary Care Accountable Care Organization (PCACO) Plan, and Children's Medical Security Plan</b>
<input type="checkbox"/> <b>MassHealth Drug Utilization Review Program</b> Pharmacy: Fax: (877) 208-7428 - Tel: (800) 745-7318
<b>MassHealth Managed Care Organization (MCO) and Accountable Care Partnership Plans (ACPP)</b>
<input type="checkbox"/> <b>Fallon Health</b> Online Prior Authorization: <a href="http://go.covermymeds.com/OptumRx">go.covermymeds.com/OptumRx</a> Online Prior Authorization: <a href="http://providerportal.surescripts.net/ProviderPortal/optum">providerportal.surescripts.net/ProviderPortal/optum</a> Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033
<input type="checkbox"/> <b>Health New England</b> Online Prior Authorization: <a href="http://go.covermymeds.com/OptumRx">go.covermymeds.com/OptumRx</a> Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545
<input type="checkbox"/> <b>Mass General Brigham Health Plan</b> Online Prior Authorization (Pharmacy Benefit Reviews): <a href="http://go.covermymeds.com/OptumRx">go.covermymeds.com/OptumRx</a> Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555 Online Prior Authorization (Medical Specialty Reviews): <a href="http://provider.massgeneralbrighamhealthplan.org">provider.massgeneralbrighamhealthplan.org</a> Medical Specialty Reviews: Fax: (888) 656-6671 - Tel: (833) 895-2611
<input type="checkbox"/> <b>Tufts Health Plan</b> Online Prior Authorization: <a href="http://point32health.promptpa.com">point32health.promptpa.com</a> Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985
<input type="checkbox"/> <b>WellSense Health Plan</b> Online Prior Authorization: <a href="http://wellsense.org/providers/ma/pharmacy/prior-authorizations">wellsense.org/providers/ma/pharmacy/prior-authorizations</a> Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822

# Anti-Hemophilia Non-Gene Therapy 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

- Alhemo (concizumab-mtci)
- Hymravzi (marstacimab-hncq)
- Qfitlia (fitusiran)

### Dose and frequency of medication requested

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

- Hemophilia A
- Hemophilia B
- Other

Please indicate severity.  Moderately severe to severe  Severe

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

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

Is this member a referral candidate for care coordination?  Yes  No

If yes, MassHealth will offer care coordination services to this member. Please describe which additional behavioral health services would be beneficial. *Please inform the member, parent, or legal guardian to expect outreach from a MassHealth representative of care coordination services.*

## Section I. Please complete questions for all requests.

1. Member's current weight  Date
2. Is the prescriber a hematologist?  Yes  No. Please attach consultation notes from a hematologist.
3. Baseline annual bleeding rate (ABR)  Date
4. For Alhemo, has the member tried bypassing agents?
  - Yes. Please describe the dates/duration of use and outcome.  
Dates/duration of use
  - Did the member experience any of the following?  Adverse reaction  Inadequate response  Other  
Briefly describe the details of adverse reaction, inadequate response, or other.
  - No. Please describe why bypassing agents are not appropriate for this member.

5. For Alhemo, Hymravzi, and Qfitlia, has the member received any prior gene therapy for the requested diagnosis?

Yes. Please describe.   No

6. For Qfitlia, please provide results from an FDA-cleared test confirming > 60% antithrombin activity.

7. For Hymravzi, is the member able to maintain venous access for infusions?  Yes  No

8. For Hymravzi 300 mg weekly dosing, has the member tried 150 mg weekly dosing?

Yes. Please describe the dates/duration of use and outcome.

Dates/duration of use

Did the member experience any of the following?  Adverse reaction  Inadequate response  Other

Briefly describe the details of adverse reaction, inadequate response, or other.

No. Please explain why not.

9. For Hymravzi 300 mg weekly dosing, has the member had breakthrough bleeds within a 6-month period?

Yes. Please provide the number of breakthrough bleeds, including dates.

No

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## Section II. Please also complete for hemophilia A.

1. Has the member tried Hemlibra?

Yes. Please describe the dates/duration of use and outcome.

Dates/duration of use

Did the member experience any of the following?  Adverse reaction  Inadequate response  Other

Briefly describe the details of adverse reaction, inadequate response, or other.

No. Please describe why Hemlibra is not appropriate for this member.

2. For Alhemo and Hymravzi, does the member have factor VIII inhibitor? (Please attach a copy of test.)

Yes  No

3. For Hymravzi, has the member tried factor VIII products?  Yes. Please complete questions below.  No

If used as on-demand therapy, has the member had  $\geq 6$  acute bleeding episodes that required coagulation with factor VIII infusion within 6 months before discontinuation?  Yes  No

Please provide details.

If used as prophylaxis therapy, has the member had an inadequate response or adverse reaction while compliant (defined as  $\geq 80\%$  compliance with factor VIII regimen within 6 months before discontinuation)?

Yes  No

Please provide details.

4. Will the member be receiving other hemophilia A prophylaxis in conjunction with requested agent?

Yes. Please provide details.   No

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## Section III. Please also complete for moderately severe to severe hemophilia B.

1. For Alhemo and Hymravzi, does the member have factor IX inhibitor? (Please attach a copy of test.)  Yes

No

2. For Alhemo, has the member tried factor IX products?  
 Yes. Please describe the dates/duration of use and outcome.  
 Dates/duration of use   
 Did the member experience any of the following?  Adverse reaction  Inadequate response  Other  
 Briefly describe the details of adverse reaction, inadequate response, or other.  
  
  
 No. Please describe why factor IX products are not appropriate for this member.
3. For Hympavzi, has the member tried factor IX products?  Yes. Please complete questions below.  No  
 If used as on-demand therapy, has the member had  $\geq 6$  acute bleeding episodes that required coagulation with factor IX infusion within 6 months before discontinuation?  Yes  No  
 Please provide details.   
 If used as prophylaxis therapy, has the member had an inadequate response or adverse reaction while compliant (defined as  $\geq 80\%$  compliance with factor IX regimen within 6 months before discontinuation)?  
 Yes  No  
 Please provide details.
4. Will the member be receiving other hemophilia B prophylaxis in conjunction with requested agent?  
 Yes. Please provide details.   
 No
5. For Qfitlia for members without inhibitors, has the member tried factor IX products?  
 Yes. Please describe the dates/duration of use and outcome.  
 Dates/duration of use   
 Did the member experience any of the following?  Adverse reaction  Inadequate response  Other  
 Briefly describe the details of adverse reaction, inadequate response, or other.  
  
 No. Please describe why factor IX products are not appropriate for this member.
6. For Qfitlia for members with inhibitors, has the member tried a bypassing agent?  
 Yes. Please describe the dates/duration of use and outcome.  
 Dates/duration of use   
 Did the member experience any of the following?  Adverse reaction  Inadequate response  Other  
 Briefly describe the details of adverse reaction, inadequate response, or other.  
  
 No. Please describe why bypassing agents are not appropriate for this member.

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**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  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 healthcare 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"/>
		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.)