



# 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

# Pulmonary Hypertension 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** (Check one or all that apply. Where applicable, the brand name is provided in brackets for reference.)

- |   |  |
|---|--|
| <input type="checkbox"/> Adempas (riociguat)                              | <input type="checkbox"/> Tadalafil (tadalafil suspension)            |
| <input type="checkbox"/> ambrisentan                                      | <input type="checkbox"/> treprostinil injection                      |
| <input type="checkbox"/> bosentan   | <input type="checkbox"/> Tyvaso (treprostinil inhalation solution)   |
| <input type="checkbox"/> Liqrev (sildenafil oral suspension)              | <input type="checkbox"/> Tyvaso DPI (treprostinil inhalation powder) |
| <input type="checkbox"/> Opsumit (macitentan)                             | <input type="checkbox"/> Uptravi (selexipag)                         |
| <input type="checkbox"/> Opsynvi (macitentan/tadalafil)                   | <input type="checkbox"/> Ventavis (iloprost inhalation)              |
| <input type="checkbox"/> Orenitram (treprostinil extended-release tablet) | <input type="checkbox"/> Winrevair (sotatercept-csrk)                |
| <input type="checkbox"/> sildenafil 20 mg tablet                          | <input type="checkbox"/> Yutrepia (treprostinil inhalation powder)   |
| <input type="checkbox"/> sildenafil oral suspension [Revatio]             | <input type="checkbox"/> Other* <input type="text"/>                 |
| <input type="checkbox"/> tadalafil tablet                                 |  |

\* 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

Is the member stabilized on the requested medication?

- Yes. Please provide start date.   No

## Section I. Please complete for all requests.

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

- |  |  |
|--|--|
| <input type="checkbox"/> Chronic thromboembolic pulmonary hypertension (CTEPH) | <input type="checkbox"/> Pulmonary hypertension associated with interstitial lung disease (PH-ILD) |
| <input type="checkbox"/> Pulmonary arterial hypertension (PAH)                 | <input type="checkbox"/> Other (Please indicate.) <input type="text"/>                             |

**Please indicate prescriber specialty below.**

- Cardiology  Pulmonology  Other (Please indicate.)

## Section II. Please also complete for tadalafil tablet and Tadalafil requests.

1. Has the member tried sildenafil 20 mg tablet (Revatio)?

- Yes. Please provide the following information.\*

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. Does the member have a contraindication to sildenafil? Please explain.

2. Is the member treatment naïve?  Yes  No

If yes, will the requested agent be used in combination with ambrisentan?  Yes  No

3. Will the requested agent be administered concurrently with Adempas?  Yes. Please explain below.  No

4. For Tadiq, please provide medical necessity for the use of the requested formulation instead of tadalafil tablet.

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**Section III. Please also complete for Adempas requests.**

1. Will Adempas be administered concurrently with a phosphodiesterase-5 inhibitor (sildenafil or tadalafil)?

Yes. Please explain below.  No

2. For members with CTEPH, please describe surgical history and/or prognosis.

3. For members with pulmonary arterial hypertension, has the member tried sildenafil or tadalafil?

Yes. Please provide the following information.\*

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.

No. Does the member have a contraindication to sildenafil and tadalafil? Please explain.

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**Section IV. Please also complete for Orenitram, treprostinil injection, Tyvaso, Tyvaso DPI, Ventavis, and Yutrepia for PAH requests.**

1. Has the member tried epoprostenol (Veletri) or Flolan?

Yes. Please provide the following information.\*

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. Does the member have a contraindication to epoprostenol (Veletri) or Flolan, or is the member unable to use epoprostenol? Please explain.

2. For Tyvaso DPI and Yutrepia, please attach medical records documenting inadequate response, adverse reaction, or contraindication to Tyvaso inhalation solution, or clinical rationale why the member is unable to use inhalation solution.

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**Section V. Please also complete for Tyvaso DPI and Yutrepia for PH-ILD requests.**

Please attach medical records documenting inadequate response, adverse reaction, or contraindication to Tyvaso inhalation solution, or clinical rationale why the member is unable to use inhalation solution.

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**Section VI. Please also complete for Liqrev, sildenafil 20 mg tablet and oral suspension [Revatio] requests.**

1. Will sildenafil be administered concurrently with Adempas?  Yes. Please explain below.  No

2. For Liqrev and sildenafil oral suspension [Revatio], please provide medical necessity for the use of the requested formulation instead of sildenafil tablet.

3. For Liqrev, please provide medical necessity for the use of the requested formulation instead of sildenafil oral suspension [Revatio].

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

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**Section VII. Please also complete for bosentan for suspension requests.**

Member's current weight

Date

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**Section VIII. Please also complete for Uptravi requests.**

1. For Uptravi tablet requests exceeding quantity limit, please describe the clinical rationale for exceeding quantity limit or why dose cannot be consolidated.

2. For Uptravi vial requests, please complete the following.

Is the member stabilized on Uptravi tablets?

Yes. Please provide start date.

No

Is the member temporarily unable to take oral medications?

Yes. Please explain.

No

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**Section IX. Please also complete for Opsynvi requests.**

1. Please provide medical necessity for the use of the combination product instead of the commercially available separate agents.

2. Will the requested agent be administered concurrently with Adempas?  Yes. Please explain below.  No

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**Section X. Please also complete for Winrevair requests.**

1. Member's current weight

Date

2. Please document member's current WHO functional class.  I  II  III  IV

3. Is the member stable on background therapy for PAH?  Yes  No

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**Section XI. 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

over

If yes, briefly describe details of contraindication, adverse reaction, or harm.

  

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.

  

2. 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.

  

3. 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.)