



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
<input type="checkbox"/> 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)
<input type="checkbox"/> Fallon Health Online Prior Authorization: go.covermymeds.com/OptumRx Online Prior Authorization: providerportal.surescripts.net/ProviderPortal/optum Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033
<input type="checkbox"/> Health New England Online Prior Authorization: go.covermymeds.com/OptumRx Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545
<input type="checkbox"/> Mass General Brigham Health Plan Online Prior Authorization (Pharmacy Benefit Reviews): go.covermymeds.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
<input type="checkbox"/> Tufts Health Plan Online Prior Authorization: point32health.promptpa.com Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985
<input type="checkbox"/> WellSense Health Plan Online Prior Authorization: wellsense.org/providers/ma/pharmacy/prior-authorizations Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822

Beta Thalassemia, Myelodysplastic Syndrome, and Sickle Cell Disease 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.

Medication information

Medication requested

Adakveo (crizanlizumab-tmca) ^{MB}

l-glutamine

Reblozyl (luspatercept-aamt) ^{MB}

Rytelo (imetelstat) ^{MB}

Siklos (hydroxyurea tablet)

Xromi (hydroxyurea solution)

^{MB} This drug is available through the health care professional who administers the drug or in an outpatient or inpatient hospital setting. MassHealth does not pay for this drug to be dispensed through the retail pharmacy. If listed, PA does not apply through the acute hospital inpatient setting, unless on the APAD/APEC carve-out drug list, or in the emergency, trauma, or urgent acute hospital outpatient settings. Please refer to 130 CMR 433.408 for PA requirements for other health care professionals. Notwithstanding the above, this drug may be an exception to the unified pharmacy policy; please refer to respective MassHealth Accountable Care Partnership Plans (ACPPs) and Managed Care Organizations (MCOs) for PA status and criteria, if applicable.

Dose, frequency, and duration of medication requested

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

Beta Thalassemia (provide documentation of genetic testing)

Myelodysplastic syndromes associated anemia

Sickle Cell Disease (SCD)

Other

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

Is the prescriber a hematologist?

Yes

No. Please attach consultation notes from a hematologist addressing the use of the requested agent.

Member's current weight

Date

Section I. Please complete for Adakveo requests.

1. Has the member experienced two or more sickle cell crises in the last 12 months?

Yes. Please provide dates.

No

2. Has the member had an inadequate response to hydroxyurea for at least three months? Please note: trial will be evaluated to ensure titration to maximally tolerated dose.*

Yes. Please note: requests will be evaluated taking into account MassHealth pharmacy claims history or additional documentation addressing adherence to this agent.

Dose and frequency

Dates of use

Outcome

Please attach hematologic laboratory data (e.g., absolute neutrophil count [ANC], platelet count, hemoglobin, reticulocyte count) supporting dosing regimen.

No

3. Has the member tried hydroxyurea and had an adverse reaction or does the member have a contraindication to this agent?*

Yes. Please explain.

No

4. For recertification requests, please attach medical records documenting positive response to therapy (e.g., follow up information on vaso-occlusive crises, pain management, hospitalizations, and/or member's improvement).

Section II. Please complete for I-glutamine requests.

1. Has the member experienced two or more sickle cell crises in the last 12 months?

Yes. Please provide dates.

No

2. Has the member had a trial with hydroxyurea?*

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

Dates/duration of use

Adverse reaction

Inadequate response

Other

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

No. Please explain why not.

Section III. Please complete for Reblozyl for beta thalassemia requests.

1. Please attach a copy of genetic test confirming diagnosis of beta thalassemia.

2. Is the member transfusion-dependent?

Yes. Please attach medical records supporting regular blood transfusions and/or chronic iron chelator use.

No

3. For recertification requests, please attach medical records documenting positive response to therapy (e.g., follow up information on transfusion requirements and/or member's improvement).

Section IV. Please complete for Siklos and Xromi requests.

Please document medical necessity for the use of the requested formulation.

Section V. Please complete for Rytelo requests.

1. Has the member required \geq four RBC transfusions within the last eight weeks?

Yes. Please describe.

No

2. Has the member had a trial with an erythropoiesis stimulating agent (e.g., epoetin, darbepoetin)?

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

Drug name

Dose and frequency

Dates/duration of use

Adverse reaction

Inadequate response

Other

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

No. Please explain why not.

3. If the member has MDS with ring sideroblasts, has the member had a trial with Reblozyl?
 Yes. Please list the dose and frequency, dates/duration of use, and outcomes below.
 Dose and frequency 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, or other.

 No. Please explain why not.
4. If the member has MDS associated with a del 5q cytogenic abnormality, has the member had a trial with lenalidomide?
 Yes. Please list the dose and frequency, dates/duration of use, and outcomes below.
 Dose and frequency 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, or other.

 No. Please explain why not.

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.)