



# 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

# Dermatological Agents (Topical Chemotherapy and Genital Wart Therapy) 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 requested

- |  |   |
|--|---|
| <input type="checkbox"/> Ameluz (aminolevulinic acid) <sup>MB</sup>  | <input type="checkbox"/> Veregen (sinecatechins)            |
| <input type="checkbox"/> fluorouracil 0.5% cream                     | <input type="checkbox"/> Ycanth (cantharidin) <sup>MB</sup> |
| <input type="checkbox"/> imiquimod 3.75% cream                       | <input type="checkbox"/> Zelsuvvmi (berdazimer)             |
| <input type="checkbox"/> Levulan (aminolevulinic acid) <sup>MB</sup> |   |

<sup>MB</sup> 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 ICD-10 code, if applicable

- |   |   |
|---|---|
| <input type="checkbox"/> Actinic keratosis<br><input type="checkbox"/> Face <input type="checkbox"/> Scalp <input type="checkbox"/> Upper extremities | <input type="checkbox"/> Molluscum contagiosum      |
| <input type="checkbox"/> External genital warts   | <input type="checkbox"/> Other <input type="text"/> |
| <input type="checkbox"/> Perianal warts   | (Attach a letter regarding medical necessity.)      |

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 the prescriber a dermatologist?

- Yes
- No. For Ameluz and Levulan requests, please attach consultation notes from a dermatologist addressing the use of the requested agent.

## Section I. Please complete for treatment of actinic keratosis with fluorouracil 0.5% cream or imiquimod 3.75% cream.

1. Has the member had a trial with topical fluorouracil 2% solution, 5% solution or 5% cream?

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

Dates/duration   Adverse reaction  Inadequate response  Other

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

- No. Please document if there is a contraindication to topical fluorouracil therapy.

2. For imiquimod 3.75% cream, has the member tried imiquimod 5% cream?

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

Dates/duration   Adverse reaction  Inadequate response  Other

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

No. Please document if there is a contraindication to imiquimod 5% cream.

**Section II. Please complete for Ameluz and Levulan requests.**

1. Has the member had a trial with topical fluorouracil or topical imiquimod?

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

Drug name

Dates/duration   Adverse reaction  Inadequate response  Other

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

No. Please document if there is a contraindication to topical fluorouracil and topical imiquimod.

2. Has the member tried and failed cryosurgery?  Yes  No

3. Will the requested agent be used in conjunction with photodynamic therapy?  Yes  No

4. For Ameluz requests, has the member had a trial with Levulan used in conjunction with photodynamic therapy?

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

Dates/duration   Adverse reaction  Inadequate response  Other

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

No. Please document if there is a contraindication to Levulan used in conjunction with photodynamic therapy.

**Section III. Please complete for Ycanth and Zelsuvmi requests.**

1. Has the member had a trial with topical podofilox, potassium hydroxide, salicylic acid, or topical retinoid, if applicable?

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

Drug name  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 document if there is a contraindication to these trials.

2. Has the member tried and failed cryotherapy?  Yes  No

3. Has the member tried and failed curettage?  Yes  No

4. For Zelsuvmi requests for members  $\geq 2$  years of age, has the member had a trial with Ycanth?

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

Dates/duration   Adverse reaction  Inadequate response  Other

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

No. Please document if there is a contraindication to Ycanth.

\* Please attach a letter with additional information regarding medication trials as applicable.

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**Section IV. Please complete for treatment of external genital warts or perianal warts with imiquimod 3.75% cream or Veregen.**

1. Has the member had a trial with topical podofilox, or podophyllum resin applied by a provider?

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

Drug name

Dates/duration

Adverse reaction  Inadequate response  Other

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

No. Please document if there is a contraindication to topical podofilox and podophyllum resin.

2. If the request is for imiquimod 3.75% cream, has the member had a trial with imiquimod 5% cream?

Dates/duration

Adverse reaction  Inadequate response  Other

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

No. Please document if there is a contraindication to imiquimod 5% cream.

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**Section V. 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

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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.)