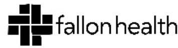

Prior Authorization Request Administrative Information

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 ______

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.covermymeds.com/OptumRx Online Prior Authorization: providerportal.surescripts.net/ProviderPortal/optum Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033
☐ **Health New England** Online Prior Authorization: go.covermymeds.com/OptumRx Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545
☐ **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
☐ **Tufts Health Plan** Online Prior Authorization: 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 Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822

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Wound Care
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

☐ Filsuvez (birch triterpenes)
☐ Nexobrid (anacaulase-bcdb)[MB]
☐ Regranex (becaplermin)
☐ Santyl (collagenase)
☐ Vyjuvek (beremagene geperpavec-svdt)
☐ Other

Dose, frequency, and duration of medication requested

[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.

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

☐ Chronic dermal ulcers or severely burned areas
☐ Dystrophic epidermolysis bullosa (DEB) (provide documentation of genetic testing)
☐ Deep partial thickness and/or full thickness thermal burns
☐ Diabetic neuropathic ulcers in the lower extremities
☐ Junctional epidermolysis bullosa (JEB) (provide documentation of genetic testing)
☐ 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.

Is the prescriber a specialist in wound care?

☐ Yes

☐ No. For Filsuvez, Nexobrid, and Vyjuvek, please attach consultation notes from a specialist (e.g., burn specialist, dermatologist, geneticist, histopathologist, etc.) addressing the use of the requested agent.

Section I. Please complete for Filsuvez, Nexobrid, and Vyjuvek requests.

1. For Filsuvez, does the member have at least one partial thickness wound that is clean in appearance and does not appear infected? ☐ Yes ☐ No
2. For Filsuvez for the diagnosis of DEB, will the requested agent be used in combination with Vyjuvek? ☐ Yes ☐ No
3. For Nexobrid, please provide BSA of wound area.
4. For Vyjuvek requests, does the member have at least one cutaneous wound that is clean in appearance with adequate granulation tissue, has excellent vascularization, and does not appear infected? ☐ Yes ☐ No

Section II. Please complete for Regranex requests.

1. Please provide number and size of the ulcers intended for treatment.
2. Please provide duration of the intended treatment.
3. Do any of the member's ulcers extend to subcutaneous tissue or beyond? ☐ Yes ☐ No
4. Is the ulcer clear of infection? ☐ Yes ☐ No
5. Do the member's lower extremities have adequate blood supply? ☐ Yes ☐ No
6. Does the member have ≥ 2 months of good wound care (sharp debridement, saline dressing, and pressure relief) without adequate ulcer healing? ☐ Yes ☐ No

Section III. Please complete for Santyl requests.

1. Please provide number and size of the ulcers and/or lesions intended for treatment.
2. Please provide duration of the intended treatment.
3. Is the member a candidate for surgical intervention alone? ☐ Yes ☐ No
4. Is the member a candidate for autolytic debridement? ☐ Yes ☐ No
5. Will the requested agent be used in combination with surgery? ☐ Yes ☐ No

Section IV. Please also complete for recertification requests.

1. Has the member demonstrated improvement in ulcer or wound including size? ☐ Yes ☐ No
   If yes, please describe.
2. For Filsuvez, is the requested agent being applied on target wounds that have completely healed?
   ☐ Yes ☐ No
3. For Nexobrid, does the member have a new thermal burn?
   ☐ Yes. Please provide BSA of wound area.
   ☐ No. Please provide medical necessity for continued use.
4. For Vyjuvek, does the member have complete wound healing of at least one wound after 6 months of treatment?
   ☐ Yes
   ☐ No. Please provide medical necessity for continued used despite lack of efficacy.

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

Please continue to next page and complete Prescriber and Provider Information section.

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Prior Authorization Request Prescriber and Provider Information

Prescriber information

Last name* First name* MI

NPI* Individual MH Provider ID

DEA No. Office Contact Name

Address City State Zip

E-mail address

Telephone No.*

Fax No.* (Please provide fax number for PA response notification.)

** Required*

Please also complete for professionally administered medications, if applicable.

Start date End date

Servicing prescriber/facility name ☐ Same as prescribing provider

Servicing provider/facility address

Servicing provider NPI/tax ID No.

Name of billing provider

Billing provider NPI No.

Is this a request for recertification? ☐ Yes ☐ No

CPT code No. of visits J code No. of units

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

Date

(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.)