



# 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

- 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](http://go.covermymeds.com/OptumRx)  
Online Prior Authorization: [providerportal.surescripts.net/ProviderPortal/optum](http://providerportal.surescripts.net/ProviderPortal/optum)  
Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033

- Health New England**  
Online Prior Authorization: [go.covermymeds.com/OptumRx](http://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](http://go.covermymeds.com/OptumRx)  
Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555  
Online Prior Authorization (Medical Specialty Reviews): [provider.massgeneralbrighamhealthplan.org](http://provider.massgeneralbrighamhealthplan.org)  
Medical Specialty Reviews: Fax: (888) 656-6671 - Tel: (833) 895-2611

- Tufts Health Plan**  
Online Prior Authorization: [point32health.promptpa.com](http://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](http://wellsense.org/providers/ma/pharmacy/prior-authorizations)  
Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822

# Hereditary Angioedema 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).

## Diagnosis

Is the member diagnosed with hereditary angioedema?  Yes  No

Please provide any lab tests that confirm the diagnosis.

Test	<input type="text"/>	Lab value	<input type="text"/>	Lab reference range	<input type="text"/>	Date obtained	<input type="text"/>
Test	<input type="text"/>	Lab value	<input type="text"/>	Lab reference range	<input type="text"/>	Date obtained	<input type="text"/>
Test	<input type="text"/>	Lab value	<input type="text"/>	Lab reference range	<input type="text"/>	Date obtained	<input type="text"/>

Please document the baseline frequency of hereditary angioedema attacks:  attacks/month

## Medication information

### Medication requested

- |  |   |
|--|---|
| <input type="checkbox"/> Andembry (garadacimab-gxii)                                     | <input type="checkbox"/> icatibant > six injections/30 days                                       |
| <input type="checkbox"/> Berinert (c1 esterase inhibitor, human) > 14 injections/30 days | <input type="checkbox"/> Kalbitor (ecallantide) <sup>MB</sup> >12 injections/30 days              |
| <input type="checkbox"/> Cinryze (c1 esterase inhibitor, human)                          | <input type="checkbox"/> Orladeyo (berotralstat)  |
| <input type="checkbox"/> Dawnzera (donidalorsen)   | <input type="checkbox"/> Ruconest (c1 esterase inhibitor, recombinant) > eight injections/30 days |
| <input type="checkbox"/> Ekterly (sebetralstat)  | <input type="checkbox"/> Takhzyro (lanadelumab-flyo)  |
| <input type="checkbox"/> Haegarda (c1 esterase inhibitor, human)                         |   |

<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.

Instructions for use

Prophylaxis therapy  Treatment of acute attacks

Place of administration  Clinician's office  Home

Has the member been instructed to self-administer the medication?  Yes  No

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 member under the care of an allergist or immunologist?  Yes  No

If yes, and the requesting provider is not the allergist or immunologist, please provide consult notes.

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**Section I. Please complete for requests for quantities above quantity limits for Berinert, icatibant, Kalbitor, and Ruconest.**

Is the member experiencing more than two HAE attacks/30 days?  Yes  No

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**Section II. For Andembry, Cinryze, Dawnzera, Haegarda, Orladeyo, and Takhzyro requests, please complete the following.**

1. Is the member experiencing more than one HAE attack/30 days?  Yes  No
  2. Does the member have a history of recurrent laryngeal attacks?  Yes  No
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**Section III. For Ekterly requests, please complete the following.**

1. Has the member tried two of the following: Berinert, icatibant, Kalbitor, Ruconest?

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

Drug name  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, contraindication, or other.

Drug name  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, contraindication, or other.

No. Please describe why Berinert, icatibant, Kalbitor, and Ruconest are not appropriate for this member.

2. Is the member experiencing more than two HAE attacks/30 days?  Yes  No
- 

**Section IV. For recertification requests for Ekterly, please complete the following.**

Is the requested quantity  $\leq$  eight tablets/30 days?  Yes  No

If no, is the member experiencing more than two HAE attacks/30 days?  Yes  No

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**Section V. For recertification requests for Takhzyro, please complete the following.**

1. Please indicate requested dosing frequency.  Every four weeks  Every two weeks
2. For requested dosing every two weeks, please indicate the number of HAE attacks in the last six months.  
 Member has had  $\geq$  one HAE attack in the last six months.  
 Member has been HAE attack free for  $\geq$  six months. Please provide clinical rationale for every two-week dosing instead of every four-week dosing.

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**Section VI. For recertification requests for Dawnzera, please complete the following.**

1. Please indicate requested dosing frequency.  Every eight weeks  Every four weeks
2. For requested dosing every four weeks, please indicate the number of HAE attacks in the last six months.  
 Member has had  $\geq$  one HAE attack in the last six months.  
 Member has been HAE attack free for  $\geq$  six months. Please provide clinical rationale for every four-week dosing instead of every eight-week dosing.

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**Section VII. 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"/>
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.)