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MassHealth fallon health Health New England Where you matter. Mass General Brigham Health Plan TUFTS Health Plan WellSense HEALTH PLAN

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 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

Anti-Hemophilia Non-Gene Therapy 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

☐ Alhemo (concizumab-mtci)
☐ Hemlibra (emicizumab-kxwh)
☐ Hympavzi (marstacimab-hncq)
☐ Qfitlia (fitusiran)

Dose and frequency of medication requested

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

☐ Hemophilia A
☐ Hemophilia B
☐ Other

Please indicate severity. ☐ Moderately severe to severe ☐ Severe
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 this member a referral candidate for care coordination? ☐ Yes ☐ No
If yes, MassHealth will offer care coordination services to this member**.** Please describe which additional behavioral health services would be beneficial. *Please inform the member, parent, or legal guardian to expect outreach from a MassHealth representative of care coordination services.*

Section I. Please complete questions for all requests.

1. Member's current weight Date
2. Is the prescriber a hematologist? ☐ Yes ☐ No. Please attach consultation notes from a hematologist.
3. Baseline annual bleeding rate (ABR) Date
4. For Alhemo, has the member tried bypassing agents?

   ☐ Yes. Please describe the dates/duration of use and outcome.

   Dates/duration of use

   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.

   ☐ No. Please describe why bypassing agents are not appropriate for this member.

5. For Alhemo, Hympavzi, and Qfitlia, has the member received any prior gene therapy for the requested diagnosis?

   ☐ Yes. Please describe. ☐ No

6. For Qfitlia, please provide results from an FDA-cleared test confirming > 60% antithrombin activity.
7. For Hympavzi, is the member able to maintain venous access for infusions? ☐ Yes ☐ No
8. For Hympavzi 300 mg weekly dosing, has the member tried 150 mg weekly dosing?
   ☐ Yes. Please describe the dates/duration of use and outcome.

   Dates/duration of use

   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

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

   ☐ No. Please explain why not.

9. For Hympavzi 300 mg weekly dosing, has the member had breakthrough bleeds within a 6-month period?

   ☐ Yes. Please provide the number of breakthrough bleeds, including dates.

   ☐ No

Section II. Please also complete for hemophilia A requests, excluding Hemlibra.

1. Has the member tried Hemlibra?
   ☐ Yes. Please describe the dates/duration of use and outcome.

   Dates/duration of use

   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

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

   ☐ No. Please describe why Hemlibra is not appropriate for this member.

2. For Alhemo and Hympavzi, does the member have factor VIII inhibitor? (Please attach a copy of test.)
   ☐ Yes ☐ No
3. For Hympavzi, has the member tried factor VIII products? ☐ Yes. Please complete questions below. ☐ No

   If used as on-demand therapy, has the member had ≥ 6 acute bleeding episodes that required coagulation with factor VIII infusion within 6 months before discontinuation? ☐ Yes ☐ No

   Please provide details.

   If used as prophylaxis therapy, has the member had an inadequate response or adverse reaction while compliant (defined as ≥ 80% compliance with factor VIII regimen within 6 months before discontinuation)?
   ☐ Yes ☐ No

   Please provide details.
4. Will the member be receiving other hemophilia A prophylaxis in conjunction with requested agent?

   ☐ Yes. Please provide details. ☐ No

Section III. Please also complete for moderately severe to severe hemophilia B.

1. For Alhemo and Hympavzi, does the member have factor IX inhibitor? (Please attach a copy of test.) ☐ Yes ☐ No

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2. For Alhemo, has the member tried factor IX products?
   ☐ Yes. Please describe the dates/duration of use and outcome.

   Dates/duration of use
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.

   ☐ No. Please describe why factor IX products are not appropriate for this member.

3. For Hympavzi, has the member tried factor IX products? ☐ Yes. Please complete questions below. ☐ No
   If used as on-demand therapy, has the member had ≥ 6 acute bleeding episodes that required coagulation with factor IX infusion within 6 months before discontinuation? ☐ Yes ☐ No

   Please provide details.
   If used as prophylaxis therapy, has the member had an inadequate response or adverse reaction while compliant (defined as ≥ 80% compliance with factor IX regimen within 6 months before discontinuation)?
   ☐ Yes ☐ No

   Please provide details.
4. Will the member be receiving other hemophilia B prophylaxis in conjunction with requested agent?

   ☐ Yes. Please provide details.
   ☐ No
5. For Qfitlia for members without inhibitors, has the member tried factor IX products?
   ☐ Yes. Please describe the dates/duration of use and outcome.

   Dates/duration of use
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.

   ☐ No. Please describe why factor IX products are not appropriate for this member.

6. For Qfitlia for members with inhibitors, has the member tried a bypassing agent?
   ☐ Yes. Please describe the dates/duration of use and outcome.

   Dates/duration of use
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.

   ☐ No. Please describe why bypassing agents are not appropriate for this member.

Section IV. 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.

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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 healthcare 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.)