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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

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Gonadotropin-Releasing Hormone 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

- ☐ Camcevi (leuprolide)
- ☐ Eligard (leuprolide)
- ☐ Fensolvi (leuprolide)
- ☐ Firmagon (degarelix)
- ☐ leuprolide 22.5 mg vial
- ☐ Lupron (leuprolide)
- ☐ Lutrate (leuprolide)
- ☐ Myfembree (relugolix/estradiol/norethindrone)
- ☐ Orgovyx (relugolix)
- ☐ Oriahnn (elagolix/estradiol/norethindrone)
- ☐ Orilissa (elagolix)
- ☐ Supprelin LA (histrelin)
- ☐ Synarel (nafarelin)
- ☐ Trelstar (triptorelin)
- ☐ Triptodur (triptorelin)

Dose, frequency, and duration of medication requested

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

- ☐ Advanced breast cancer
- ☐ Advanced prostate cancer
- ☐ Endometrial thinning prior to ablation for abnormal uterine bleeding
- ☐ Endometriosis
- ☐ Gender Dysphoria
- ☐ Idiopathic or neurogenic central precocious puberty (CPP)
- ☐ Uterine leiomyomata (fibroids)
- ☐ 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.

Section I. Please complete for requests for idiopathic or neurogenic CPP.

1. Provide age of secondary sex characteristics onset.
2. Is the member under the care of a pediatric endocrinologist?
   ☐ Yes. Name of member's pediatric endocrinologist Date of last visit
   ☐ No. Please attach medical records of a consultation with a pediatric endocrinologist.
3. For members ≥11 years of age and < 12 years of age (female sex assigned at birth/biologic females) or ≥12 years of age and <13 years of age (male sex assigned at birth/biologic males), does the member require one additional year of prolonged therapy due to developmental delay? ☐ Yes. ☐ No.
4. For Lupron Ped 11.25 mg (1-month or 3-month), Lupron Ped 15 mg (1-month), 30 mg (3-month), has the member tried Lupron Ped 7.5 mg monthly and experienced an inadequate response?
   ☐ Yes. Please provide date and outcome for trial.
   Date(s) Outcome(s)
   ☐ No. Please explain.

5. For Lupron Ped 45 mg, has the member tried Fensolvi and Lupron Ped 7.5 mg monthly and experienced an inadequate response?
   ☐ Yes. Provide drug names, dates, and outcomes for trials below.
   Drug name Date(s) Outcome(s)
   Drug name Date(s) Outcome(s)
   ☐ No. Please explain.
6. For Triptodur, has the member tried Fensolvi or Lupron Ped and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please provide date and outcome for trial.
   Date(s) Outcome(s)
   ☐ No. Please explain.

Section II. Please complete for requests for endometriosis.

1. Has the member tried non-steroidal anti-inflammatory drugs (NSAIDs) and experienced an adverse reaction or inadequate response?
   ☐ Yes. Provide drug names, dates, and outcomes for trials below.
   Drug name(s) Date(s) Outcome(s)
   ☐ No. Please explain if there is a contraindication to this trial.
2. Has the member tried hormonal contraceptives and experienced an adverse reaction or inadequate response?
   ☐ Yes. Provide drug names, dates, and outcomes for trials below.
   Drug name(s) Date(s) Outcome(s)
   ☐ No. Please explain if there is a contraindication to this trial.
3. For Myfembree and Orilissa, has the member tried leprolide and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please provide date and outcome for trial.
   Date(s) Outcome(s)
   ☐ No. Please explain if there is a contraindication to this trial.
4. For Lupron 11.25 mg every 3 months, has the member tried Lupron 3.75 mg monthly and had an inadequate response?
   ☐ Yes. Please provide date and outcome for trial.
   Date(s) Outcome(s)
   ☐ No. Please explain if there is a contraindication to this trial.

Section III. Please complete for requests for endometrial thinning prior to ablation for abnormal uterine bleeding and uterine leiomyomata (fibroids).

1. Is surgery planned?
   ☐ Yes. Please provide anticipated date of surgery.
   ☐ No. Please explain.
2. Has the member tried hormonal contraceptives and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please provide date and outcome for trial.

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Date(s) Outcome(s)

☐ No. Please explain.

3. For Lupron 11.25 mg every 3 months, has the member tried Lupron 3.75 mg monthly and had an inadequate response?
   ☐ Yes. Please provide date and outcome for trial.
   Date(s) Outcome(s)
   ☐ No. Please explain if there is a contraindication to this trial.
4. For Myfembree and Oriahnn, has the member tried leuprolide and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please provide date and outcome for trial.
   Date(s) Outcome(s)
   ☐ No. Please explain.
5. For Myfembree, has the member tried Oriahnn and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please provide date and outcome for trial.
   Date(s) Outcome(s)
   ☐ No. Please explain.

Section IV. Please complete for requests for advanced prostate cancer.

1. Please indicate prescriber specialty. ☐ Oncology ☐ Urology ☐ Other
2. For Lupron Depot, please describe clinical rationale for use instead of the equivalent dose of Eligard.
3. For Lupron Depot, has the member tried Lutrate and experienced an adverse reaction or inadequate response?
   ☐ Yes. Provide drug names, dates, and outcomes for trials below.
   Drug name(s) Date(s) Outcome(s)
   ☐ No. Please explain.
4. For Orgovyx, has the member tried leuprolide and experienced an adverse reaction or inadequate response?
   ☐ Yes. Provide drug names, dates, and outcomes for trials below.
   Drug name(s) Date(s) Outcome(s)
   ☐ No. Please explain.
5. For Lupron Depot and Orgovyx, has the member tried Firmagon and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please provide date and outcome for trial.
   Date(s) Outcome(s)
   ☐ No. Please explain.

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6. For Lupron Depot and Orgovyx, has the member tried Trelstar and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please provide date and outcome for trial.
   Drug name(s) Date(s) Outcome(s)
   ☐ No. Please explain.

Section V. Please complete for requests for gender dysphoria.

For Lupron 7.5 mg, 22.5 mg, 30 mg, and 45 mg adult kit, please describe clinical rationale for use instead of the equivalent dose of Eligard.

Section VI. Please complete for all other diagnoses, excluding advanced breast cancer.

Please describe the medical necessity for the use of gonadotropin-releasing hormone, including previous trials and outcomes, and dates of any relevant lab tests (including but not limited to bone mineral density).

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.

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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.)