



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
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<input type="checkbox"/> 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)

<input type="checkbox"/> Fallon Health Online Prior Authorization: go.covermy meds.com/OptumRx Online Prior Authorization: providerportal.surescripts.net/ProviderPortal/optum Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033
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<input type="checkbox"/> Health New England Online Prior Authorization: go.covermy meds.com/OptumRx Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545

<input type="checkbox"/> Mass General Brigham Health Plan Online Prior Authorization (Pharmacy Benefit Reviews): go.covermy meds.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
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<input type="checkbox"/> Tufts Health Plan Online Prior Authorization: point32health.promptpa.com Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985
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<input type="checkbox"/> 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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Targeted Immunomodulators 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	Requested indication
Anti-TNFs (See Section I for all requests, as applicable.)	
<input type="checkbox"/> Abrilada (adalimumab-afzb) <input type="checkbox"/> adalimumab-aacf, unbranded <input type="checkbox"/> adalimumab-aaty, unbranded <input type="checkbox"/> adalimumab-adaz, unbranded <input type="checkbox"/> adalimumab-adbm, unbranded <input type="checkbox"/> adalimumab-fkjp, unbranded <input type="checkbox"/> adalimumab-ryvk, unbranded <input type="checkbox"/> Amjevita (adalimumab-atto) <input type="checkbox"/> Avsola (infliximab-axxq) <input type="checkbox"/> Cimzia (certolizumab) <input type="checkbox"/> Cyltezo (adalimumab-adbm) <input type="checkbox"/> Enbrel (etanercept) <input type="checkbox"/> Hadlima (adalimumab-bwwd) <input type="checkbox"/> Hulio (adalimumab-fkjp) <input type="checkbox"/> Humira (adalimumab) <input type="checkbox"/> Hyrimoz (adalimumab-adaz) <input type="checkbox"/> Inflectra (infliximab-dyyb) <input type="checkbox"/> infliximab, unbranded <input type="checkbox"/> Remicade (infliximab) <input type="checkbox"/> Renflexis (infliximab-abda) <input type="checkbox"/> Simlandi (adalimumab-ryvk) <input type="checkbox"/> Simponi (golimumab) <input type="checkbox"/> Simponi Aria (golimumab for infusion) <input type="checkbox"/> Yuflyma (adalimumab-aaty) <input type="checkbox"/> Yusimry (adalimumab-aqvh) <input type="checkbox"/> Zymfentra (infliximab-dyyb)	<input type="checkbox"/> Ankylosing spondylitis (AS) (Section VII) <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Fistulizing Crohn's disease <input type="checkbox"/> Hidradenitis suppurativa (HS) (Hurley Stage II or III) <input type="checkbox"/> Non-infectious uveitis (Section XIII) <input type="checkbox"/> Non-radiographic axial spondyloarthritis (nr-AxSpA) (Section XI) <input type="checkbox"/> Plaque psoriasis (PsO) (Section IV) <input type="checkbox"/> Polyarticular juvenile idiopathic arthritis (Section VI) <input type="checkbox"/> Psoriatic arthritis (PsA) <input type="checkbox"/> Rheumatoid arthritis (RA) (Section II) <input type="checkbox"/> Ulcerative colitis (UC) <input type="checkbox"/> Other <input style="width: 150px; height: 15px;" type="text"/>
Interleukin Antagonists (See Section I for all requests, as applicable.)	
<input type="checkbox"/> Actemra (tocilizumab auto-injection, prefilled syringe) <input type="checkbox"/> Actemra (tocilizumab vial) ^{MB} <input type="checkbox"/> Adbry (tralokinumab-ldrm) <input type="checkbox"/> Arcalyst (rilonacept)	<input type="checkbox"/> Adult-onset Still's disease (AOSD) (Section XIX) <input type="checkbox"/> Ankylosing spondylitis (AS) (Section VII) <input type="checkbox"/> Atopic dermatitis (Section IX) <input type="checkbox"/> Crohn's disease (Section VIII) <input type="checkbox"/> Fistulizing Crohn's disease

Interleukin Antagonists cont. (See Section I for all requests, as applicable.)

- Bimzelx (bimekizumab-bkzx)
- Cosentyx (secukinumab auto-injection, prefilled syringe)
- Cosentyx (secukinumab 125 mg/5 mL vial)^{MB}
- Ebglyss (lebrikizumab-lbkz)
- Ilaris (canakinumab)
- Ilumya (tildrakizumab-asmn)
- Imuldosa (ustekinumab-srlf prefilled syringe)
- Imuldosa (ustekinumab-srlf vial)^{MB}
- Kevzara (sarilumab)
- Kineret (anakinra)
- Omvoh (mirikizumab-mrkz)
- Otulfi (ustekinumab-aaaz prefilled syringe, 45 mg/0.5 mL vial)
- Otulfi (ustekinumab-aaaz 130 mg/26 mL vial)^{MB}
- Pyzchiva (ustekinumab-ttwe prefilled syringe, 45 mg/0.5 mL vial)
- Pyzchiva (ustekinumab-ttwe 130 mg/26 mL vial)^{MB}
- Selarsdi (ustekinumab-aekn prefilled syringe, 45 mg/0.5 mL vial)
- Selarsdi (ustekinumab-aekn 130 mg/26 mL vial)^{MB}
- Skyrizi (risankizumab-rzaa)
- Spevigo (spesolimab-sbzo) (Section XXVI)
- Stelara (ustekinumab 45 mg/0.5 mL prefilled syringe, 90 mg/mL prefilled syringe, 45 mg/0.5 mL vial)
- Stelara (ustekinumab 130 mg/26 mL vial)^{MB}
- Steqeyma (ustekinumab-stba prefilled syringe, 45 mg/0.5 mL vial)
- Steqeyma (ustekinumab-stba 130 mg/26 mL vial)^{MB}
- Taltz (ixekizumab)
- Tofidence (tocilizumab-bavi)^{MB}
- Tremfya (guselkumab)
- Tyenne (tocilizumab-aaazg auto-injection, prefilled syringe)
- Tyenne (tocilizumab-aaazg vial)^{MB}
- ustekinumab-aekn, unbranded prefilled syringe
- ustekinumab-ttwe, unbranded prefilled syringe, 45 mg/0.5 mL vial
- ustekinumab-ttwe, unbranded 130 mg/26 mL vial^{MB}
- Yesintek (ustekinumab-kfce prefilled syringe, 45 mg/0.5 mL vial)
- Yesintek (ustekinumab-kfce 130 mg/26 mL vial)^{MB}

- Cytokine release syndrome (Section XII)
- Deficiency of interleukin-1 receptor antagonist (DIRA) (Section XVI)
- Enthesitis-related arthritis (ERA)
- Familial cold autoinflammatory syndrome (FCAS) (Section XVII)
- Familial Mediterranean fever (FMF) (Section XVIII)
- Generalized Pustular Psoriasis
- Giant cell arteritis (GCA) (Section XIV)
- Gout flares (Section X)
- Hidradenitis suppurativa (HS) (Hurley Stage II or III) (Section XXVII)
- Hyperimmunoglobulin D syndrome (HIDS)/ Mevalonate kinase deficiency (MKD) (Section XVIII)
- Juvenile idiopathic arthritis (JIA)
 - Polyarticular (Section VI)
 - Systemic (Section XIX, XX)
- Muckle-Wells syndrome (MWS) (Section XVII)
- Neonatal-onset multisystem inflammatory disease (NOMID)
- Non-radiographic axial spondyloarthritis (nr-AxSpA)
- Plaque psoriasis (PsO) (Section IV)
- Polymyalgia rheumatica (PMR) (Section XXIV)
- Psoriatic arthritis (PsA) (Section V)
- Recurrent pericarditis (Section XXII)
- Rheumatoid arthritis (RA) (Section II)
- Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD) (Section XV)
- Tumor necrosis factor receptor associated periodic syndrome (TRAPS) (Section XVIII)
- Ulcerative colitis (UC) (Section III)
- Other

Oral Janus Kinase Inhibitors (See Section I for all requests, as applicable.)

- Cibinqo (abrocitinib)
- Leqselvi (deuruxolitinib)

- Alopecia areata (Section XXIII)
- Ankylosing spondylitis (AS) (Section VII)

Oral Janus Kinase Inhibitors cont. (See Section I for all requests, as applicable.)

- Litfulo (ritlecitinib)
- Olumiant (baricitinib)
- Rinvoq (upadacitinib ER tablet)
- Rinvoq LQ (upadacitinib oral solution)
- Xeljanz (tofacitinib)
- Xeljanz XR (tofacitinib extended-release)

- Atopic dermatitis (Section IX)
- Crohn's disease (Section VIII)
 - Fistulizing Crohn's disease
- Giant cell arteritis (GCA) (Section XIV)
- Non-radiographic axial spondyloarthritis (nr-AxSpA) (Section XI)
- Polyarticular juvenile idiopathic arthritis (Section VI)
- Psoriatic arthritis (PsA) (Section V)
- Rheumatoid arthritis (RA) (Section II)
- Ulcerative colitis (UC) (Section III)
- Other

Miscellaneous Agents (See Section I for all requests, as applicable.)

- Entyvio (vedolizumab)
- Orencia (abatacept auto-injection, prefilled syringe)
- Orencia (abatacept vial)^{MB}
- Otezla (apremilast)
- Otezla XR (apremilast extended-release)
- Rhapsido (remibrutinib)
- Sotyktu (deucravacitinib)
- Tyruko (natalizumab-sztn)
- Velsipity (etrasimod)
- Zeposia (ozanimod)

- Acute graft versus host disease (aGVHD) prophylaxis (Section XXI)
- Chronic spontaneous urticaria (Section XXVIII)
- Crohn's disease (Section VIII)
 - Fistulizing Crohn's disease
- Polyarticular juvenile idiopathic arthritis (Section VI)
- Oral ulcers associated with Behcet's disease
- Plaque psoriasis (PsO) (Section IV)
- Psoriatic arthritis (PsA) (Section V)
- Rheumatoid arthritis (RA) (Section II)
- Ulcerative colitis (UC) (Section III, XXV)
- Other

^{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 and criteria, if applicable.

Section I. Please complete for all requests, as applicable.

1. Dose, frequency, and duration of medication requested
2. Member's current weight Date
3. 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
4. Is the member stabilized on the requested medication? Yes. Please provide start date.
 No
5. Please indicate prescriber specialty below.
 Allergy/Immunology Dermatology Gastroenterology Rheumatology Other
6. Please specify severity of indication.
 Mild Mild-moderate Moderate Moderate-severe Severe

7. For quantities above quantity limits, please describe the clinical rationale for exceeding the quantity limit. Requested dose must be consolidated to use the minimum number of units to achieve requested dose. For doses that are not consolidated, please describe clinical rationale why the dose cannot be consolidated.
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8. For Abrilada, Amjevita, Cyltezo, Hulio, Humira, Hyrimoz, Simlandi, Yuflyma, Yusimry, and unbranded adalimumab generics (excluding adalimumab-adaz), has the member had a trial with Hadlima and adalimumab-adaz?
- Yes. Please attach medical records documenting an inadequate response or adverse reaction to Hadlima and adalimumab-adaz.
- No. Please document clinical rationale for use of the requested agent instead of Hadlima and adalimumab-adaz.
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9. For Actemra, please provide clinical rationale for use instead of Tyenne.
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10. For Cimzia vial, please provide medical necessity for the requested formulation instead of Cimzia prefilled syringe.
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11. For Cimzia, all infliximab products, Simponi, and Simponi Aria, please provide clinical rationale for use instead of adalimumab and Enbrel, if applicable. For requests for all infliximab products and Simponi for a diagnosis of UC, a trial with adalimumab is not required.
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12. For Inflectra, Remicade, and Renflexis, please provide clinical rationale for use instead of unbranded infliximab and Avsola.
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13. For Olumiant, Rinvoq, and Rinvoq LQ, please document a trial with Xeljanz or Xeljanz XR, or provide clinical rationale for use of the requested agent instead of both Xeljanz and Xeljanz XR, if applicable.
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14. For Omvoh 100 mg/mL pen and syringe or 200 mg dose pack for Crohn's disease, please provide medical necessity for use of the requested formulation instead of the 300 mg dose pack. For Omvoh 300 mg dose pack for ulcerative colitis, please provide medical necessity for use of the requested formulation instead of the 100 mg/mL pen and syringe or 200 mg dose pack.
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15. For Otezla XR, please provide medical necessity for use instead of Otezla immediate-release 30 mg tablets.
-
16. For Otulfi, Selarsdi, Stelara, Yesintek, and unbranded ustekinumab generics, has the member had a trial with Imuldosa, Pyzchiva, and Steqeyma?
- Yes. Please attach medical records documenting an inadequate response or adverse reaction to Imuldosa, Pyzchiva, and Steqeyma.
- No. Please document clinical rationale for use of the requested agent instead of Imuldosa, Pyzchiva, and Steqeyma.
-
17. For Rinvoq LQ, please provide medical necessity for use of the oral solution formulation.
-
18. For Zymfentra, please document the medical necessity for the subcutaneous formulation instead of an intravenous infliximab formulation.
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Is the member currently stable on an infliximab product? Yes No

If yes, provide start date. If no, explain why not.

Section II. Please also complete for treatment of RA with Actemra, any adalimumab product, Avsola, Cimzia, Enbrel, Inflectra, unbranded infliximab, Kevzara, Kineret, Olumiant, Orencia, Remicade, Renflexis, Rinvoq, Simponi, Simponi Aria, Tofidence, Tyenne, Xeljanz, or Xeljanz XR.

1. Has the member tried traditional disease-modifying antirheumatic drugs (DMARDs)?
 Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 No. Please explain why not.
2. Has the member tried one biologic DMARD that is FDA-approved for RA?
 Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 No. Please explain why not.
3. For Olumiant and Rinvoq has the member tried tocilizumab?
 Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 No. Please explain why not.

Section III. Please also complete for treatment of UC with Entyvio, Rinvoq, Tremfya, Xeljanz, and Xeljanz XR.

1. For Entyvio, Rinvoq, Xeljanz, and Xeljanz XR, has the member tried one anti-TNF agent that is FDA-approved for UC?
 Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 No. Please explain why not.
2. For Tremfya, has the member tried Skyrizi, Omvoh, ustekinumab and one anti-TNF agent that is FDA-approved for UC?
 Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 No. Please explain why not.
3. For Rinvoq, has the member tried ustekinumab?
 Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 No. Please explain why not.

Section IV. Please also complete for treatment of PsO with any adalimumab product, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Ilumya, Imuldosa, Inflectra, unbranded infliximab, Otezla, Otezla XR, Remicade, Renflexis, Skyrizi, Sotyktu, Stelara, Taltz, Tremfya, or any ustekinumab product.

For Otezla and Otezla XR requests, only question 1 is required. For Sotyktu requests, only questions 2 and 5 are required. For all other requests, please complete questions 1 through 4, as applicable.

1. Has the member tried other therapies to treat this condition including topical agents, systemic agents, and phototherapy?
 Yes. Please list the names of therapies, dates/duration of trials, and outcomes in Section XXIX below.*
 No. Please explain why not.
2. Has the member tried one biologic DMARD that is FDA-approved for PsO?
 Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 No. Please explain why not.

3. For Bimzelx, Cosentyx, and Ilumya, and for Tremfya for members ≥ 18 years, has the member tried Skyrizi, Taltz, ustekinumab, and one anti-TNF agent that is FDA-approved for PsO?
 - Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 - No. Please explain why not.
4. For Tremfya for members \geq six to < 18 years, has the member tried Otezla, Taltz, ustekinumab, and one anti-TNF agent that is FDA-approved for PsO?
 - Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 - No. Please explain why not.
5. For Sotyktu, has the member tried Otezla?
 - Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 - No. Please explain why not.

Section V. Please also complete for treatment of PsA with any adalimumab product, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Inflectra, Orenzia, Otezla, Otezla XR, Remicade, Renflexis, Rinvoq, Rinvoq LQ, Simponi, Skyrizi, Taltz, Tremfya, any ustekinumab product, Xeljanz, or Xeljanz XR.

1. Has the member tried traditional disease-modifying antirheumatic drugs (DMARDs)?
 - Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 - No. Please explain why not.
2. Has the member tried one biologic DMARD that is FDA-approved for RA?
 - Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 - No. Please explain why not.
3. For Bimzelx, and for Cosentyx and Tremfya for members ≥ 18 years, has the member also tried Skyrizi, Taltz, and ustekinumab?
 - Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 - No. Please explain why not.
4. For Cosentyx for members \geq two to < 18 years, has the member also tried adalimumab or Enbrel?
 - Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 - No. Please explain why not.
5. For Tremfya for members \geq six to < 18 years, has the member also tried adalimumab or Enbrel, and both Otezla and ustekinumab?
 - Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 - No. Please explain why not.
6. For Bimzelx, Cosentyx and Tremfya for members ≥ 18 years, Orenzia, Rinvoq, Rinvoq LQ, Xeljanz, and Xeljanz XR, has the member tried one anti-TNF agent that is FDA-approved for PsA?
 - Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 - No. Please explain why not.
7. For Rinvoq and Rinvoq LQ, for members < 18 years, has the member tried Otezla?
 - Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 - No. Please explain why not.
8. For Rinvoq and Rinvoq LQ, for members ≥ 18 years, has the member tried Otezla and Taltz?
 - Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 - No. Please explain why not.

Section VI. Please also complete for treatment of polyarticular JIA with Actemra, any adalimumab product, Cimzia, Enbrel, Kevzara, Oencia, Rinvoq, Rinvoq LQ, Simponi Aria, Tofidence, Tyenne, or Xeljanz.

For Kevzara requests, only questions 1, 2, and 4 are required. For all other requests, please complete questions 1 through 3.

1. Has the member tried traditional disease-modifying antirheumatic drugs (DMARDs)?
 Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 No. Please explain why not.
2. Has the member tried one biologic DMARD that is FDA-approved for polyarticular JIA?
 Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 No. Please explain why not.
3. For Xeljanz, has the member tried one anti-TNF agent?
 Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 No. Please explain why not.
4. For Kevzara, has the member tried adalimumab or Enbrel?
 Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 No. Please explain why not.
5. For Rinvoq and Rinvoq LQ, has the member tried tocilizumab and one anti-TNF agent?
 Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 No. Please explain why not.

Section VII. Please also complete for treatment of AS with anti-TNFs, Bimzelx, Cosentyx, Rinvoq, Taltz, Xeljanz, and Xeljanz XR.

1. Has the member tried two nonsteroidal anti-inflammatory drugs (NSAIDs)?
 Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 No. Please explain why not.
2. For Bimzelx, Cosentyx, Rinvoq, Xeljanz, and Xeljanz XR, has the member tried one anti-TNF agent that is FDA-approved for AS?
 Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 No. Please explain why not.
3. For Bimzelx, Cosentyx, and Rinvoq, has the member tried Taltz?
 Yes. Please list the drug name, dates/duration of trial, and outcome in Section XXIX below.*
 No. Please explain why not.

Section VIII. Please also complete for treatment of Crohn's disease with Entyvio, Rinvoq, Tremfya and Tyruko.

1. For Entyvio, Rinvoq and Tremfya, has the member tried one anti-TNF agent that is FDA-approved for Crohn's disease?
 Yes. Please list the drug name, dates/duration of trial, and outcome in Section XXIX below.*
 No. Please explain why not.
2. For Tremfya, has the member tried Omvoh, Skyrizi, and ustekinumab?
 Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 No. Please explain why not.

3. For Rinvoq, has the member tried ustekinumab?
 Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 No. Please explain why not.
4. For Tyruko, please provide clinical rationale for use instead of Tysabri.

Section IX. Please complete for treatment of atopic dermatitis with Adbry, Cibinqo, Ebglyss, and Rinvoq.

1. Body surface area (BSA) to be treated
2. Has the member tried a superpotent or potent topical corticosteroid to treat this condition?
 Yes. Please list the drug name, dates/duration of trial, and outcome in Section XXIX below.*
 No. Please explain why not.
3. Has the member tried topical tacrolimus or Eucrisa to treat this condition?
 Yes. Please list the drug name, dates/duration of trial, and outcome in Section XXIX below.*
 No. Please explain why not.
4. Has the member tried other medications to treat this condition, including a systemic immunomodulatory agent?
 Yes. Please list the drug name, dates/duration of trial, and outcome in Section XXIX below.*
 No. Please explain why not.
5. For Cibinqo and Rinvoq, has the member tried Adbry, Dupixent, or Ebglyss to treat this condition?
 Yes. Please list the drug name, dates/duration of trial, and outcome in Section XXIX below.*
 No. Please explain why not.
6. For Cibinqo 200 mg tablet, has the member tried Cibinqo 100 mg dose?
 Yes. Please list the drug name, dates/duration of trial, and outcome in Section XXIX below.*
 No. Please explain why not.
7. For Rinvoq, has the member tried Cibinqo to treat this condition?
 Yes. Please list the drug name, dates/duration of trial, and outcome in Section XXIX below.*
 No. Please explain why not.

Section X. Please also complete for treatment of gout flares with Ilaris.

Has the member tried colchicine, corticosteroids, and NSAIDs?

- Yes. Please list the drug names, dates/duration of trial, and outcome in Section XXIX below.*
 No. Please explain why not.

Section XI. Please also complete for treatment of nr-AxSpA with Bimzelx, Cimzia, Cosentyx, Rinvoq, and Taltz.

1. Has the member tried two nonsteroidal anti-inflammatory drugs (NSAIDs)?
 Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 No. Please explain why not.
2. For Bimzelx, Cosentyx, and Rinvoq, has the member tried one anti-TNF agent and Taltz?
 Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 No. Please explain why not.

Section XII. Please complete for treatment of cytokine release syndrome with Actemra IV, Tofidence, and Tyenne.

Please provide anticipated date of administration with concurrent CAR T-cell therapy.

Section XIII. Please complete for treatment of non-infectious uveitis with Humira and adalimumab.

Has the member tried other medications to treat this condition including glucocorticoid and immunosuppressive therapy?

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

No. Please explain why not.

Section XIV. Please complete for treatment of GCA with Actemra, Rinvoq, Tofidence, and Tyenne.

1. Has the member tried other medications to treat this condition including glucocorticoid therapy?

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

No. Please explain why not.

2. For Rinvoq has the member tried tocilizumab?

Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*

No. Please explain why not.

Section XV. Please complete for treatment of SSc-ILD with Actemra SC and Tyenne SC.

Has the member tried cyclophosphamide or mycophenolate?

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

No. Please explain why not.

Section XVI. Please complete for treatment of DIRA with Arcalyst and Kineret.

1. Has the diagnosis been confirmed through genetic testing? Yes No

2. For Arcalyst, has the member tried Kineret?

Yes. Please list the drug name, dates/duration of trial, and outcome in Section XXIX below.*

No. Please explain why not.

Section XVII. Please complete for treatment of FCAS and MWS with Arcalyst and Ilaris.

1. Has the diagnosis been confirmed through genetic testing? Yes No

If no, does the member have evidence of symptoms indicative of the disease?

Yes. Please explain.

No

2. For Arcalyst, has the member tried Ilaris?

Yes. Please list the drug name, dates/duration of trial, and outcome in Section XXIX below.*

No. Please explain why not.

Section XVIII. Please complete for treatment of FMF, HIDS/MKD, and TRAPS with Ilaris.

1. Has the diagnosis been confirmed through genetic testing? Yes No

If no, does the member have evidence of symptoms indicative of the disease?

Yes. Please explain.

No

2. If the request is for treatment of FMF, has the member tried colchicine?
- Yes. Please list the drug name, dates/duration of trial, and outcome in Section XXIX below.*
- No. Please explain why not.
-

Section XIX. Please complete for treatment of AOSD and systemic JIA with Ilaris.

Has the member tried other medications to treat this condition, including corticosteroids and Kineret?

- Yes. Please list the drug name, dates/duration of trials, and outcomes in Section XXIX below.*
- No. Please explain why not.
-

Section XX. Please complete for treatment of systemic JIA with Actemra, Tofidence, and Tyenne.

1. Has the member tried a traditional DMARD?

- Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
- No. Please explain why not.

2. Has the member tried one biologic DMARD that is FDA-approved for systemic JIA?

- Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
- No. Please explain why not.
-

Section XXI. Please complete for aGVHD prophylaxis with Orencia.

1. Will the requested agent be used in combination with a calcineurin inhibitor?

- Yes. Please list drug name, dose, and frequency below.

Drug name Dose and frequency

- No. Please explain why not.

2. Will the requested agent be used in combination with methotrexate?

- Yes. Please list dose and frequency.

- No. Please explain why not.
-

Section XXII. Please complete for treatment of recurrent pericarditis with Arcalyst.

1. Has the member tried aspirin or NSAIDs?

- Yes. Please list the drug name, dates/duration of trial, and outcome in Section XXIX below.*

- No. Please explain why not.

2. Has the member tried colchicine, corticosteroids, and Kineret?

- Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*

- No. Please explain why not.
-

Section XXIII. Please complete for treatment of alopecia areata with Leqselvi, Litfulo, and Olumiant.

1. Has the member tried other medications to treat this condition, including a topical corticosteroid, an intralesional corticosteroid, and Xeljanz or Xeljanz XR?

- Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*

- No. Please explain why not.

2. For Leqselvi, has the member tried Litfulo?

- Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*

- No. Please explain why not.

3. For Leqselvi, does the member have decreased cytochrome P450 2C9 function? Yes No
-

Section XXIV. Please complete for treatment of PMR with Kevzara.

1. Has the member tried a systemic corticosteroid to treat this condition?
 Yes. Please list the drug name, dates/duration of trial, and outcome in Section XXIX below.*
 No. Please explain why not.
2. Has the member tried methotrexate to treat this condition?
 Yes. Please list the drug name, dates/duration of trial, and outcome in Section XXIX below.*
 No. Please explain why not.
-

Section XXV. Please also complete for treatment of UC with Velsipity and Zeposia.

1. Has the member tried one anti-TNF agent that is FDA-approved for UC?
 Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.*
 No. Please explain why not.
2. Has the member tried Entyvio?
 Yes. Please list the drug name, dates/duration of trial, and outcome in Section XXIX below.*
 No. Please explain why not.
-

Section XXVI. Please also complete for Spevigo.

1. For Spevigo prefilled syringe, has the member tried a biologic DMARD?
 Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XXIX below.
 No. Please explain why not.
2. For Spevigo prefilled syringe, has the member had a positive response to treatment for an acute pustular psoriasis flare using Spevigo vial? Yes No
-

Section XXVII. Please also complete for treatment of HS with Bimzelx and Cosentyx.

1. For Bimzelx, has the member tried adalimumab and Cosentyx?
 Yes. Please list the drug name, dates/duration of trial, and outcome in Section XXIX below.*
 No. Please explain why not.
2. For Cosentyx, has the member tried adalimumab?
 Yes. Please list the drug name, dates/duration of trial, and outcome in Section XXIX below.*
 No. Please explain why not.
-

Section XXVIII. Please also complete for treatment of chronic spontaneous urticaria (CSU) with Rhapsido.

1. Has the member tried a second generation histamine₁ antihistamine, Dupixent, and Xolair?
 Yes. Please list the drug names, dates/duration of trial, and outcome in Section XXIX below.*
 No. Please explain why not.
2. Has the member tried an increased dose of a second generation histamine₁ antihistamine (up to four times the standard dose)?
 Yes. Please list the drug name, dates/duration of trial, and outcome in Section XXIX below.*
 No. Please explain why not.

3. Has the member tried to a second generation histamine₁ antihistamine in combination with a histamine₂ antihistamine, a leukotriene receptor antagonist, or a first-generation antihistamine at bedtime?
- Yes. Please list the drug name, dates/duration of trial, and outcome in Section XXIX below.*
- No. Please explain why not.

Section XXIX. Please complete for all requests as needed.

Please provide the following information regarding previous trials.*

Drug name/Therapy 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.

Drug name/Therapy 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.

Drug name/Therapy 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.

Drug name/Therapy 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.

Drug name/Therapy 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.

* Please attach a letter documenting additional trials as necessary.

Section XXX. 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.

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.)