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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Inhaled Respiratory 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 (Check one or all that apply. Where applicable, the brand name is provided in brackets for reference.)

Anticholinergics
- ☐ Yupelri (revefenacin)
- ☐ Tudorza (aclidinium)

Combination Products
- ☐ Airsupra (albuterol/budesonide)
- ☐ Bevespi (glycopyrrolate/formoterol)
- ☐ Breztri (budesonide/glycopyrrolate/formoterol)
- ☐ Duaklir (aclidinium/formoterol)
- ☐ fluticasone/salmeterol [Airduo Respiclick]
- ☐ Stiolto (tiotropium/olodaterol)
- ☐ Trelegy (fluticasone furoate/umeclidinium/ vilanterol)

Corticosteroids
- ☐ Alvesco (ciclesonide inhaler)
- ☐ budesonide inhalation suspension ≥ 13 years
- ☐ fluticasone propionate inhalation aerosol ≥ 12 years
- ☐ fluticasone propionate inhalation powder
- ☐ Qvar Redihaler (beclomethasone inhaler)

Long-acting Beta Agonists
- ☐ arformoterol
- ☐ formoterol
- ☐ Striverdi (olodaterol)

Short-acting Beta Agonists
- ☐ albuterol inhaler ‡
- ☐ levalbuterol inhalation solution

‡Brand name Ventolin is available without prior authorization.

Phosphodiesterase 3/phosphodiesterase 4 inhibitor
- ☐ Ohtuvayre (ensifentrine)

Other Medication
- ☐ Other* ____

**If request is for a non-preferred brand name or generic product, please attach supporting documentation (e.g., copies of medical records and/or office notes regarding adverse reaction or inadequate response to the preferred product).*

Dose and frequency of medication requested ____

Number of inhalers/month ____

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

☐ Asthma (Specify severity below.)

☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

☐ Chronic Obstructive Pulmonary Disease (COPD) (Specify severity and subtype below.)

Severity ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

Subtype ☐ Chronic bronchitis ☐ Emphysema

☐ Exercise-induced bronchospasm

☐ Reactive airway disease ☐ Other ________

Please list all other medications currently prescribed for the member for this indication. ________

____

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.*

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Section I. Please complete for albuterol inhaler requests.

1. For requests for albuterol inhaler, has the member had a trial with an albuterol product available without prior authorization? *
   ☐ Yes. Please list the dates/duration of trials, and outcomes in Section XI.
   ☐ No. Please describe the clinical rationale why albuterol product available without prior authorization is not appropriate for this member.
   ____

** Brand name Ventolin does not require prior authorization*.

Section II. Please complete for all arformoterol, budesonide inhalation suspension, formoterol, levalbuterol inhalation solution, and Yupelri requests.

1. Please describe the medical necessity for a nebulized formulation.
   ____
2. For levalbuterol inhalation solution, has the member had a trial with albuterol solution?
   ☐ Yes. Please list the dates/duration of trials, and outcomes in Section XI.
   ☐ No. Please describe the clinical rationale why albuterol solution is not appropriate for this member.
   ____
3. For Yupelri, has the member had a trial with ipratropium inhalation nebulizer solution?
   ☐ Yes. Please list the dates/duration of trials, and outcomes in Section XI.
   ☐ No. Please describe the clinical rationale why ipratropium inhalation nebulizer solution is not appropriate for this member. ________

Section III. Please complete for fluticasone/salmeterol (generic Airduo Respiclick) requests.

1. Has the member had a trial with fluticasone/salmeterol inhalation aerosol, powder (generic Advair)?
   ☐ Yes. Please list the dates/duration of trials and the outcomes in Section XI.
   ☐ No. Please describe the clinical rationale for use of the requested agent in this member.
   ____

Section IV. Please complete for Alvesco, fluticasone propionate inhalation aerosol for members ≥ 12 years of age, fluticasone propionate inhalation powder, and Qvar Redihaler requests.

Has the member had a trial with two inhaled corticosteroids?
☐ Yes. Please list the dates/duration of trials, and outcomes in Section XI.

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☐ No. Please document if there is a contraindication to all other inhaled corticosteroids.

Section V. Please complete for Bevespi and Duaklir requests.

Has the member had a trial with Stiolto or umeclidinium/vilanterol?

☐ Yes. Please list the dates/duration of trials, and outcomes in Section XI.

☐ No. Please describe the clinical rationale for use of the requested agent in this member.

Section VI. Please complete for Trelegy requests.

Has the member had a trial with fluticasone/vilanterol and umeclidinium or fluticasone furoate inhalation powder and umeclidinium/vilanterol?

☐ Yes. Please list the dates/duration of trials, and outcomes in Section XI.

☐ No. Please describe the clinical rationale for use of the requested agent in this member.

Section VII. Please complete for Breztri requests.

Has the member had a trial with the following combination of the separate agents: Bevespi and Pulmicort inhalation powder?

☐ Yes. Please list the dates/duration of trials, and outcomes in Section XI.

☐ No. Please describe the clinical rationale for use of the requested agent in this member.

Section VIII. Please complete for Airsupra requests.

Has the member had a trial with budesonide/formoterol or albuterol and Pulmicort inhalation powder?

☐ Yes. Please list the dates/duration of trials, and outcomes in Section XI.

☐ No. Please describe the clinical rationale for use of the requested agent in this member.

Section IX. Please complete for Ohtuvayre requests.

1. Has the member had a trial with Bevespi, Duaklir, Stiolto, or umeclidinium/vilanterol?

   ☐ Yes. Please list the dates/duration of trials, and outcomes in Section XI.

   ☐ No. Please describe the clinical rationale why Bevespi, Duaklir, Stiolto, and umeclidinium/vilanterol is not appropriate for this member.

2. Has the member had a trial with Breztri or Trelegy?

   ☐ Yes. Please list the dates/duration of trials, and outcomes in Section XI.

   ☐ No. Please describe the clinical rationale why Breztri and Trelegy is not appropriate for this member.

Section X. Please complete for Tudorza requests.

1. Has the member had a trial with Spiriva Respimat, tiotropium inhalation powder, or umeclidinium?

   ☐ Yes. Please list the dates/duration of trials, and outcomes in Section X.

   ☐ No. Please document if there is a contraindication to Spiriva Respimat, tiotropium inhalation powder, and umeclidinium.

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Section XI. Please complete as instructed in sections above.*

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, 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, 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, or other.

** Please attach a letter documenting additional trials as necessary.*

Section XII. 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 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.)