



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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T-cell Immunotherapies

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

- | | |
|--|---|
| <input type="checkbox"/> Columvi (glofitamab-gxmb) ^{MB} | <input type="checkbox"/> Lunsumio (mosunetuzumab-axgb) ^{MB} |
| <input type="checkbox"/> Elrexfio (elranatamab-bcmm) ^{MB} | <input type="checkbox"/> Lynozyfic (linvoseltamab-gcpt) ^{MB} |
| <input type="checkbox"/> Epkinly (epcoritamab-bysp) ^{MB} | <input type="checkbox"/> Talvey (talquetamab-tgvs) ^{MB} |
| <input type="checkbox"/> Imdelltra (tarlatamab-dlle) ^{MB} | <input type="checkbox"/> Tecvayli (teclistamab-cqyv) ^{MB} |

^{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 status and criteria, if applicable.

Dose, frequency, and duration of medication requested

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

§ Columvi requests only

‡ Elrexfio, Lynozyfic, Talvey, and Tecvayli requests only

- Extensive stage small cell lung cancer (ES-SCLC) ¶
- Relapsed or refractory follicular lymphoma (FL) after two or more lines of systemic therapy ¶*
- Relapsed or refractory DLBCL NOS, DLBCL arising from indolent lymphoma, DLBCL arising from high-grade B-cell lymphoma*

* Epkinly requests only

¶ Imdelltra requests only

¶¶ Lunsumio requests only

- Relapsed or refractory DLBCL, not otherwise specified or LBCL arising from follicular lymphoma §
- Relapsed or refractory multiple myeloma (RRMM) ‡
- Relapsed or refractory follicular lymphoma (FL) after one or more lines of systemic therapy *

Please describe pertinent mutations if applicable.

- HLA-A*02:01P HLA-A*02:02P HLA-A*02:03P HLA-A*02:06P Ph+

Please describe the cell histology, if applicable.

Please indicate prescriber specialty below.

- Hematology Oncology Other

Section I. Please complete for all requests.

- Member's current weight Date
- Please indicate billing preference. Prescriber in-office Hospital outpatient
If applicable, please also complete section for professionally administered medications at end of form.

3. Drug NDC (if known) or service code
4. Please provide anticipated dates for the following as applicable.
 Treatment date Admission Infusion Discharge
5. Please provide the infusion setting. Inpatient Outpatient
6. Will the infusion take place in a qualified treatment facility or, as applicable, a health care facility that has been certified pursuant to the Risk Evaluation and Mitigation Strategy (REMS) program specific to the treatment being provided? Yes No
7. For Epkinly and Lunsumio for relapsed/refractory FL, will the requested agent be used as monotherapy for this indication? Yes No
 If no, please list all other medications currently prescribed for the member that will be used concomitantly for this indication.

8. Please list any other prior trials including the drug names, dates/duration of use, and outcomes below. Please note, Elrexio, Talvey, and Tecvayli are FDA-approved for use after four or more lines of therapy, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 monoclonal antibody. *
- Drug Dates/duration Adverse reaction Inadequate response Other
 Briefly describe details of adverse reaction, inadequate response, or other.
- Drug Dates/duration Adverse reaction Inadequate response Other
 Briefly describe details of adverse reaction, inadequate response, or other.
- Drug Dates/duration Adverse reaction Inadequate response Other
 Briefly describe details of adverse reaction, inadequate response, or other.
- Drug Dates/duration Adverse reaction Inadequate response Other
 Briefly describe details of adverse reaction, inadequate response, or other.

**Attach a letter with additional information regarding medication trials as applicable.*

Section II. 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.)