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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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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.)	
☐ Abrilada (adalimumab-afzb) ☐ adalimumab-aacf, unbranded ☐ adalimumab-aaty, unbranded ☐ adalimumab-adaz, unbranded ☐ adalimumab-adbm, unbranded ☐ adalimumab-fkjp, unbranded ☐ adalimumab-ryvk, unbranded ☐ Amjevita (adalimumab-atto) ☐ Avsola (infliximab-axxq) ☐ Cimzia (certolizumab) ☐ Cyltezo (adalimumab-adbm) ☐ Enbrel (etanercept) ☐ Hadlima (adalimumab-bwwd) ☐ Hulio (adalimumab-fkjp) ☐ Humira (adalimumab) ☐ Hyrimoz (adalimumab-adaz) ☐ Inflectra (infliximab-dyyb) ☐ infliximab, unbranded ☐ Remicade (infliximab) ☐ Renflexis (infliximab-abda) ☐ Simlandi (adalimumab-ryvk) ☐ Simponi (golimumab) ☐ Simponi Aria (golimumab for infusion) ☐ Yuflyma (adalimumab-aaty) ☐ Yusimry (adalimumab-aqvh) ☐ Zymfentra (infliximab-dyyb)	☐ Ankylosing spondylitis (AS) (Section VII) ☐ Crohn's disease ☐ Fistulizing Crohn's disease ☐ Hidradenitis suppurativa (HS) (Hurley Stage II or III) ☐ Non-infectious uveitis (Section XIII) ☐ Non-radiographic axial spondyloarthritis (nr-AxSpA) (Section XI) ☐ Plaque psoriasis (PsO) (Section IV) ☐ Polyarticular juvenile idiopathic arthritis (Section VI) ☐ Psoriatic arthritis (PsA) ☐ Rheumatoid arthritis (RA) (Section II) ☐ Ulcerative colitis (UC) ☐ Other
Interleukin Antagonists (See Section I for all requests, as applicable.)	
☐ Actemra (tocilizumab auto-injection, prefilled syringe) ☐ Actemra (tocilizumab vial) MB ☐ Adbry (tralokinumab-ldrm) ☐ Arcalyst (rilonacept) ☐ Avtozma (tocilizumab-anoh vial) MB ☐ Bimzelx (bimekizumab-bkzx)	☐ Adult-onset Still's disease (AOSD) (Section XIX) ☐ Ankylosing spondylitis (AS) (Section VII) ☐ Atopic dermatitis (Section IX) ☐ Crohn's disease (Section VIII) ☐ Fistulizing Crohn's disease ☐ Cytokine release syndrome (Section XII)

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

- ☐ 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-aauz prefilled syringe, 45 mg/0.5 mL vial)
- ☐ Otulfi (ustekinumab-aauz 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)
- ☐ Starjemza (ustekinumab-hmny prefilled syringe, 45 mg/0.5 mL vial)
- ☐ Starjemza (ustekinumab-hmny 130 mg/26 mL vial) MB
- ☐ 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-aazg auto-injection, prefilled syringe)
- ☐ Tyenne (tocilizumab-aazg vial) MB
- ☐ ustekinumab-aauz, unbranded prefilled syringe
- ☐ 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

- ☐ 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

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Oral Janus Kinase Inhibitors (See Section I for all requests, as applicable.)	
☐ Cibinqo (abrocitinib) ☐ Leqselvi (deuruxolitinib) ☐ Litfulo (ritlecitinib) ☐ Olumiant (baricitinib) ☐ Rinvoq (upadacitinib ER tablet) ☐ Rinvoq LQ (upadacitinib oral solution) ☐ Xeljanz (tofacitinib) ☐ Xeljanz XR (tofacitinib extended-release)	☐ Alopecia areata (Section XXIII) ☐ Ankylosing spondylitis (AS) (Section VII) ☐ 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

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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.
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.
9. For Actemra auto-injection and pre-filled syringe, please provide clinical rationale for use instead of Tyenne auto-injection and prefilled syringe.
10. For Actemra vial and Tofidence, please attach medical records documenting an inadequate response, adverse reaction, or clinical rationale for use of the requested agent instead of Avtozma vial and Tyenne vial.
11. For Cimzia vial, please provide medical necessity for the requested formulation instead of Cimzia prefilled syringe.
12. 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.
13. For Inflectra, Remicade, and Renflexis, please provide clinical rationale for use instead of unbranded infliximab and Avsola.
14. 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.
15. 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.
16. For Otezla XR, please provide medical necessity for use instead of Otezla immediate-release 30 mg tablets.
17. For Imuldosa, Otulfi, Pyzchiva, Selarsdi, Stelara, Steqeyma, Yesintek, and unbranded ustekinumab generics excluding ustekinumab-aekn, has the member had a trial with Starjemza and ustekinumab-aekn?
    ☐ Yes. Please attach medical records documenting an inadequate response or adverse reaction to Starjemza and ustekinumab-aekn.
    ☐ No. Please document clinical rationale for use of the requested agent instead of Starjemza and ustekinumab-aekn.

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18. For Rinvoq LQ, please provide medical necessity for use of the oral solution formulation.

19. For Zymfentra, please document the medical necessity for the subcutaneous formulation instead of an intravenous infliximab formulation.

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, Avtozma, 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.*

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☐ 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 ≥ 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, Orencia, 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 ≥ 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 ≥ 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, Orencia, 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.

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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, Avtozma, Cimzia, Enbrel, Kevzara, Orencia, 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.

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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 Nemluvio and one of the following to treat this condition: Adbry, Dupixent, or Ebglyss?
   ☐ Yes. Please list the drug names, dates/duration of trials, and outcomes 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.

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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, Avtozma, 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, Avtozma, 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

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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, Avtozma, 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. _____

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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 histamine$_1$ 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 histamine$_1$ antihistamine (up to four times the standard dose)?
   ☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XXIX below.*

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☐ No. Please explain why not. ☐

3. Has the member tried to a second generation $histamine_1$ antihistamine in combination with a $histamine_2$ 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.
   ☐
   ☐

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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.

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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.)