Print Clear

MassHealth | fallon health | Health New England Where you matter. | Mass General Brigham Health Plan | TUFTS Health Plan | WellSense HEALTH PLAN

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

over

Renal Disorder 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

- ☐ Filspari (sparsentan)
- ☐ Jynarque (tolvaptan)
- ☐ Kerendia (finerenone)
- ☐ Lokelma (sodium zirconium cyclosilicate) > 1 packet/day
- ☐ Pokonza (potassium chloride oral solution, powder for oral solution)
- ☐ potassium chloride 40 mEq powder packet
- ☐ Samsca (tolvaptan)
- ☐ Tarpeyo (budesonide 4 mg delayed-release capsule)
- ☐ Vanrafia (atrasentan)
- ☐ Velphoro (sucroferric oxyhydroxide)
- ☐ Veltassa (patiromer 1 g packet) ≥ 18 years and > 4 packets/day
- ☐ Veltassa (patiromer 8.4 g, 16.8 g) > 1 packet/day
- ☐ Voyxact (sibeprenlimab-szsi)
- ☐ Xphozah (tenapanor 20 mg, 30 mg tablet)

Dose, frequency, and duration of medication requested

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

- ☐ Autosomal Dominant Polycystic Kidney Disease (ADPKD)
- ☐ Chronic kidney disease associated with type 2 diabetes
- ☐ Euvolemic hyponatremia (SIADH)
- ☐ Heart failure
- ☐ Hyperkalemia
- ☐ Hyperphosphatemia in chronic kidney disease on dialysis
- ☐ Hypervolemic hyponatremia (CHF)
- ☐ Hypokalemia
- ☐ Immunoglobulin A nephropathy (IgAN)
- ☐ Other

Please indicate billing preference. ☐ Pharmacy ☐ Prescriber in-office ☐ Hospital outpatient
If applicable, please also complete section for professionally administered medications at end of form.

Section I. Please complete for Filspari, Tarpeyo, Vanrafia, and Voyxact requests.

1. Is the prescriber a nephrologist? ☐ Yes ☐ No. Please attach consultation notes from a nephrologist.
2. Has the member had a trial with the maximum FDA-approved dose of an ACE inhibitor or ARB for at least three months? ☐ Yes ☐ No. Please complete all parts of question 3 below.
   If yes, please list the drug name, dates/duration of trials and outcomes below.

   Drug name Dose/Frequency

   Dates/duration of use Outcome

3. Has the member had an inadequate response to a maximally tolerated dose of an ACE inhibitor or ARB for at least three months?
   ☐ Yes. Please list the drug name, dates/duration of trials and complete outcome of trial with dose above the maximally tolerated dose below. ☐ No

   Drug name _____ Dose/Frequency _____

   Dates/duration of use _____

   Has the member had an adverse reaction to the ACE inhibitor or ARB noted above at a dose above the maximally tolerated dose? ☐ Yes. Please list the dose/frequency and outcome below. ☐ No

   Dose/Frequency _____ Outcome _____
4. Please provide lab test results and dates for urine protein-to-creatinine ratio (UPCR) or proteinuria levels after treatment with a maximally tolerated dose of an ACE inhibitor or ARB for at least three months.

   UPCR _____ g/g Date _____

   Proteinuria _____ g/day Date _____
5. For Tarpeyo, please describe the medical necessity for the delayed-release formulation instead of other glucocorticoid formulations available without PA.

   _____

   _____
6. For Voyxact, has the member had a trial with Filspari or Vanrafia?
   ☐ Yes. Please list the drug name, dates/duration of trial, and outcomes below.

   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, contraindication, or other.

   _____

   ☐ No. Please describe why Filspari and Vanrafia are not appropriate for this member.

   _____
7. For Voyxact, has the member had a trial with systemic glucocorticoids or Tarpeyo?
   ☐ Yes. Please list the drug name, dates/duration of trial, and outcomes below.

   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, contraindication, or other.

   _____

   _____

   ☐ No. Please describe why systemic glucocorticoids and Tarpeyo are not appropriate for this member.

   _____

   _____

Section II. Please complete for Jynarque and Samsca requests.

For Jynarque, please complete questions 1 and 2. For Samsca, please complete question 3.

1. Is the prescriber a nephrologist? ☐ Yes ☐ No. Please attach consultation notes from a nephrologist.
2. Please provide estimated glomerular filtration rate (eGFR) and date.

   eGFR _____ Date _____

over

3. Is the member currently taking and stabilized on the requested agent? ☐ Yes. Date ☐ No

Section III. Please complete for requests for Velphoro.

Has the member had a trial with two of the following: calcium acetate, lanthanum carbonate, or sevelamer hydrochloride or sevelamer carbonate?

☐ Yes. Please list the drug name, dates/duration of trials, and outcomes below.

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, contraindication, 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, contraindication, or other.

☐ No. Please describe why calcium acetate, lanthanum carbonate, and sevelamer hydrochloride or sevelamer carbonate are not appropriate for this member.

Section IV. Please complete for requests for Xphozah.

1. Is the prescriber a nephrologist? ☐ Yes ☐ No. Please attach consultation notes from a nephrologist.
2. Has the member had a trial with two of the following: calcium acetate, ferric citrate, lanthanum carbonate, sevelamer hydrochloride or sevelamer carbonate, Velphoro?

☐ Yes. Please list the drug name, dates/duration of trials, and outcomes below.

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, contraindication, 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, contraindication, or other.

☐ No. Please describe why calcium acetate, ferric citrate, lanthanum carbonate, sevelamer hydrochloride or sevelamer carbonate, and Velphoro are not appropriate for this member.

Section V. Please complete for requests for Kerendia.

For Kerendia for diagnosis of chronic kidney disease associated with type 2 diabetes, please complete questions 1 and 2. For Kerendia for diagnosis of heart failure, please complete questions 3-7.

1. Will the requested agent be used concurrently with an ACE inhibitor or ARB?

☐ Yes. Please document drug name with dose and frequency.

Drug name Dose and Frequency

☐ No. Please explain why not.

over

2. Has the member had a trial with one of the following: dapagliflozin, Inpefa, Invokana, Jardiance, Steglatro?
   ☐ Yes. Please list the drug name, dates/duration of trials, and outcomes below.
   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, contraindication, or other.
   ☐ No. Please describe why dapagliflozin, Inpefa, Invokana, Jardiance, and Steglatro are not appropriate for this member.
3. Is the prescriber a cardiologist? ☐ Yes ☐ No. Please attach consultation notes from a cardiologist.
4. Please document member's left ventricular ejection fraction (LVEF) and date.
   LVEF | Date
5. Has the member had a trial with eplerenone or spironolactone?
   ☐ Yes. Please list the drug name, dates/duration of trials, and outcomes below.
   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, contraindication, or other.
   ☐ No. Please describe why eplerenone and spironolactone are not appropriate for this member.
6. Has the member had a trial with one of the following: dapagliflozin, Inpefa, or Jardiance?
   ☐ Yes. Please list the drug name, dates/duration of trials, and outcomes below.
   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, contraindication, or other.
   ☐ No. Please describe why dapagliflozin, Inpefa, and Jardiance are not appropriate for this member.
7. Will the member be taking the requested medication concurrently with another mineralocorticoid receptor antagonist? ☐ Yes. Please document drug name with dose and frequency. ☐ No
   Drug name | Dose and Frequency

Section VI. Please complete for requests for Lokelma and Veltassa exceeding established age or quantity limits.

Please describe medical necessity for the use of the requested agent above age or quantity limits.

over

Section VII. Please complete for requests for Pokonza and potassium chloride 40 mEq powder packet.

1. Has the member had a trial with potassium bicarbonate, potassium chloride oral solution, and potassium chloride 20 mEq powder packet at an equivalent requested dose?
   ☐ Yes. Please list the drug name, dates/duration of trials, and outcomes below.
   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, contraindication, 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, contraindication, 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, contraindication, or other.

   ☐ No. Please describe why potassium bicarbonate, potassium chloride oral solution, and potassium chloride 20 mEq powder packet at an equivalent requested dose are not appropriate for this member.

2. For members ≥ 13 years of age, has the member had a trial with potassium chloride extended-release capsule and tablet formulation?
   ☐ Yes. Please list the drug name, dates/duration of trials, and outcomes below.
   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, contraindication, 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, contraindication, or other.

   ☐ No. Please describe why potassium chloride extended-release capsule and tablet formulation are not appropriate for this member.

3. Please describe medical necessity for the use of the requested formulation instead of other potassium chloride products available without PA.

over

Section VIII. 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.

over

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.)