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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**<br>Pharmacy: Fax: (877) 208-7428 - Tel: (800) 745-7318 |
| **MassHealth Managed Care Organization (MCO) and Accountable Care Partnership Plans (ACPP)** |
| ☐ **Fallon Health**<br>Online Prior Authorization: go.covermymeds.com/OptumRx<br>Online Prior Authorization: providerportal.surescripts.net/ProviderPortal/optum<br>Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033 |
| ☐ **Health New England**<br>Online Prior Authorization: go.covermymeds.com/OptumRx<br>Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545 |
| ☐ **Mass General Brigham Health Plan**<br>Online Prior Authorization (Pharmacy Benefit Reviews): go.covermymeds.com/OptumRx<br>Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555<br>Online Prior Authorization (Medical Specialty Reviews): provider.massgeneralbrighamhealthplan.org<br>Medical Specialty Reviews: Fax: (888) 656-6671 - Tel: (833) 895-2611 |
| ☐ **Tufts Health Plan**<br>Online Prior Authorization: point32health.promptpa.com<br>Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985 |
| ☐ **WellSense Health Plan**<br>Online Prior Authorization: wellsense.org/providers/ma/pharmacy/prior-authorizations<br>Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822 |

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# Topical Immune Suppressants
# 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**

- ☐ Anzupgo (delgocitinib)
- ☐ Eucrisa (crisaborole)
- ☐ Opzelura (ruxolitinib cream)
- ☐ pimecrolimus
- ☐ Vtama (tapinarof)
- ☐ Zoryve (roflumilast cream)
- ☐ Zoryve (roflumilast foam)

**Dose, frequency, and duration of medication requested**

**Quantity requested** grams per days

**Total body surface area (BSA) to be treated**

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

- ☐ Atopic dermatitis
- ☐ Moderate to severe chronic hand eczema
- ☐ Plaque psoriasis
- ☐ Seborrheic dermatitis
- ☐ Vitiligo
- ☐ 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 requests for Eucrisa, Opzelura, Vtama, and Zoryve cream for diagnosis of atopic dermatitis.

1. For Eucrisa, has the member had a trial with a topical calcineurin inhibitor or a topical corticosteroid?
   ☐ 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 topical calcineurin inhibitors and topical corticosteroids are not appropriate for this member.

2. For Opzelura, please provide total BSA involved
3. For Opzelura, Vtama, and Zoryve cream, has the member had a trial with a topical calcineurin inhibitor?
   ☐ 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 topical calcineurin inhibitors are not appropriate for this member.

**Section II. Please complete for pimecrolimus requests.**

1. Has the member had a trial with a topical corticosteroid?
   ☐ 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. If No, is the treatment area on the face or areas at high risk for skin atrophy?
   ☐ Yes. Please describe affected area.
   ☐ No. Please describe why topical corticosteroids are not appropriate for this member.
2. For members < 16 years of age, has the member had a trial with topical tacrolimus 0.03% or 0.1%?
   ☐ 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 topical tacrolimus 0.03% or 0.1% are not appropriate for this member.
3. For members ≥ 16 years of age, has the member had a trial with topical tacrolimus 0.1%?
   ☐ 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

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Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

☐ No. Please describe why topical tacrolimus 0.1% is not appropriate for this member.

**Section III. Please complete for requests for Vtama and Zoryve (cream and foam) for diagnosis of plaque psoriasis.**

Has the member had a trial with one of the following: topical calcineurin inhibitor, topical corticosteroid, or vitamin D analog?

☐ 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 topical calcineurin inhibitors, topical corticosteroids, and vitamin D analogs are not appropriate for this member.

**Section IV. Please complete for requests for Zoryve foam for diagnosis of seborrheic dermatitis.**

Has the member had a trial with one of the following: topical antifungal, topical calcineurin inhibitor, or topical corticosteroid?

☐ 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 topical antifungals, topical calcineurin inhibitors, and topical corticosteroids are not appropriate for this member.

**Section V. Please complete for requests for Opzelura for diagnosis of vitiligo.**

1. Is the prescriber a dermatology specialist? ☐ Yes ☐ No. If no, please attach the consultation notes from a dermatologist.
2. Please provide total BSA to be treated.
3. Has the member had a trial with a topical calcineurin inhibitor?
   ☐ Yes. Please list the drug name, dates/duration of trials, and outcomes below.

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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 topical calcineurin inhibitors are not appropriate for this member.

## Section VI. Please complete for requests for Anzupgo.

1. Has the member had a trial with a superpotent or potent topical corticosteroid?

   ☐ 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 topical superpotent or potent corticosteroids are not appropriate for this member.

2. Has the member had a trial with a topical calcineurin inhibitor?

   ☐ 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 topical calcineurin inhibitors are not appropriate for this member.

3. Has the member had a trial with Eucrisa or Zoryve?

   ☐ 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 Eucrisa and Zoryve are not appropriate for this member.

4. Has the member had a trial with both Opzelura and Vtama?

   ☐ 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

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Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

☐ No. Please describe why Opzelura and Vtama are not appropriate for this member.

## Section VII. Please complete for requests exceeding established quantity limits.

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

## 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 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.)