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Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Oral/Injectable Antifungal 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.**

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Medication requested

☐ Cresemba (isavuconazonium)*
☐ Onmel (itraconazole 200 mg tablet)
☐ Oravig (miconazole buccal tablet)
☐ posaconazole*
☐ Tolsura (itraconazole 65 mg capsule)
☐ voriconazole
☐ Other** _____

*For posaconazole IV and Cresemba IV, Section VII is also required.

**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 _____

Indication (check all that apply)

***voriconazole requests only ** Cresemba and posaconazole**

☐ *Aspergillus* endophthalmitis*
☐ *Aspergillus* keratitis*
☐ *Scedosporium* infection*
☐ *Aspergillus* infection
☐ *Fusarium* infection*
☐ *Zygomycosis* (mucormycosis)**

Please note: For posaconazole or voriconazole for the above indications, Sections I through VIII are not required.

For all indications checked below, please complete sections in parentheses

☐ Blastomycosis (Section V)
☐ Candidemia (Section II)
☐ Disseminated candidiasis (Section II)
☐ Esophageal candidiasis (Section III)
☐ Histoplasmosis (Section V)
☐ Onychomycosis (Section V)
☐ Oropharyngeal candidiasis (Section IV or VIII)
☐ Prevention of *Aspergillus* and *Candida* infections (Section I)
☐ Other _____ (Please attach a letter regarding medical necessity.)

Section I. Please complete for posaconazole and voriconazole for prevention of Aspergillus and Candida infections.

1. For posaconazole requests, is the member's age within the FDA-approved range for use (posaconazole suspension ≥ 13 years; posaconazole IV ≥ 18 years)?
   ☐ Yes. ☐ No. Please provide clinical rationale for use in non-FDA approved age.

   _____

2. For both posaconazole and voriconazole requests, does the member have one of the following?
   ☐ Hematologic malignancy with neutropenia ☐ Graft-versus-host disease
   ☐ Hematopoietic stem cell transplantation
   ☐ No. Please describe why the member requires antifungal prophylaxis.

   _____

3. For posaconazole IV, please provide clinical rationale for use of IV formulation over oral formulations.

   _____

Section II. Please complete for voriconazole for candidemia and disseminated candidiasis.

Has the member had a trial of oral fluconazole?

☐ Yes. Dates/durations of use _____
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response
Briefly describe details of adverse reaction or inadequate response.

_____

☐ No. Please describe why the member is not a candidate for oral fluconazole.

_____

Section III. Please complete for posaconazole suspension and voriconazole for esophageal candidiasis.

1. For posaconazole requests, is the member 13 years of age or older?
   ☐ Yes. ☐ No. Please provide clinical rationale for use in non-FDA-approved age.

   _____

2. For posaconazole requests, has the member had a trial of voriconazole?
   ☐ Yes. 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.

   _____

   ☐ No. Please describe why the member is not a candidate for voriconazole.

   _____

3. For both posaconazole and voriconazole requests, has the member had a trial of fluconazole?
   ☐ Yes. 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.

   _____

   ☐ No. Please describe why the member is not a candidate for fluconazole.

   _____

4. For both posaconazole and voriconazole requests, has the member had a trial of itraconazole?
   ☐ Yes. 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.

   _____

   ☐ No. Please describe why the member is not a candidate for itraconazole.

   _____

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Section IV. Please complete for posaconazole suspension and voriconazole for oropharyngeal candidiasis.

1. For posaconazole requests, is the member 13 years of age or older?
   ☐ Yes. ☐ No. Please provide clinical rationale for use in non-FDA approved age.

   _____

2. For voriconazole requests, has the member had a trial of posaconazole?
   ☐ Yes. 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.

   _____

   ☐ No. Please describe why the member is not a candidate for posaconazole.

   _____

3. For both posaconazole and voriconazole requests, has the member had a trial of oral fluconazole?
   ☐ Yes. 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.

   _____

   ☐ No. Please describe why the member is not a candidate for oral fluconazole.

   _____

4. For both posaconazole and voriconazole requests, has the member had a trial of itraconazole?
   ☐ Yes. 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.

   _____

   ☐ No. Please describe why the member is not a candidate for itraconazole.

   _____

Section V. Please complete for Onmel and Tolsura.

Please provide medical necessity for the requested formulation instead of itraconazole 100 mg capsules.

_____

Section VI. Please complete for Cresemba for the treatment of Aspergillus infection.

Has the member had a trial of voriconazole?

☐ Yes. 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.

_____

☐ No. Please describe why the member is not a candidate for voriconazole.

_____

Section VII. Please complete for Cresemba IV and posaconazole IV.

Please provide clinical rationale for use of IV formulation over oral formulations.

_____

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Section VIII. Please complete for Oravig for oropharyngeal candidiasis.

1. Has the member had a trial of nystatin suspension?
   ☐ Yes. 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.
   _____
   ☐ No. Please describe why the member is not a candidate for nystatin suspension.
   _____
2. Has the member had a trial of clotrimazole troches?
   ☐ Yes. 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.
   _____
   ☐ No. Please describe why the member is not a candidate for clotrimazole troches.
   _____

Section IX. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

_____

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.* _____

* *Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my 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.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____