



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

Luxturna 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

Dose, frequency, and duration requested _____

Indication

Biallelic RPE65 mutation-associated retinal dystrophy

^This drug is available through the health care professional who administers the drug. MassHealth does not pay for this drug to be dispensed through a retail pharmacy.

Please indicate prescriber specialty below.

Ophthalmologist Retinal specialist Other _____

Section I. Please complete for all requests

1. Please provide anticipated dates for retinal surgery.
 Initial treatment date _____
 Subsequent treatment date _____
2. Please provide medical records documenting the results from genetic testing showing mutations in the RPE65 gene.
3. Please provide documentation of baseline full-field light sensitivity threshold (FST) scores. _____
4. Does the member have viable retinal cells (e.g., retinal thickness >100 microns)? Yes No
5. Has the member had ocular surgery within the past six months? Yes No
6. Has the member discontinued retinoid compounds for at least the past 18 months? Yes No
7. Will the treatment procedure be performed at a specialized treatment center? Yes No
8. Outreach for both short- and long-term monitoring for efficacy and durability of response will be conducted by MassHealth. The applicable information [including but not limited to medical records confirming the dates of surgery and documenting the initial response to therapy (e.g. FST scores)] will be provided to MassHealth upon request. Yes No

Section II. 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.

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

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 _____