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

Print Clear

Pulmonary Arterial Hypertension 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 (Check one or all that apply. Where applicable, the brand name is provided in brackets for reference.)

☐ Adempas (riociguat)
☐ ambrisentan
☐ bosentan
☐ epoprostenol [Veletri]
☐ Opsumit (macitentan)
☐ Orenitram (treprostinil extended-release tablet)
☐ sildenafil 20 mg tablet – Section I only required
☐ sildenafil oral suspension
☐ tadalafil
☐ treprostinil injection
☐ Tyvaso (treprostinil inhalation)
☐ Uptravi (selexipag)
☐ Ventavis (iloprost inhalation)
☐ Other* _____

** 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, frequency, and duration of medication requested _____

Is the member stabilized on the requested medication?

☐ Yes. Please provide start date. _____ ☐ No

Section I. Please complete for all requests.

Indication (Check all that apply.)

☐ Chronic thromboembolic pulmonary hypertension (CTEPH)
☐ Pulmonary arterial hypertension (PAH)
☐ Pulmonary hypertension associated with interstitial lung disease (PH-ILD)
☐ Other (Please indicate.) _____

Please indicate prescriber specialty below.

☐ Cardiology ☐ Pulmonology ☐ Other (Please indicate.) _____

Please attach copies of medical records and/or office notes from cardiologist or pulmonologist regarding the diagnosis.

Section II. Please also complete for tadalafil requests.

Has the member tried sildenafil 20 mg tablet?

☐ Yes. Please provide the following information.*
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. Does the member have a contraindication to sildenafil? Please explain.
_____

Section III. Please also complete for Adempas requests.

1. Will Adempas be administered concurrently with a phosphodiesterase-5 inhibitor (sildenafil or tadalafil)?
   ☐ Yes. Please explain below. ☐ No
   _____
2. For members with CTEPH, please describe surgical history and/or prognosis.
   _____
3. For members with pulmonary arterial hypertension, has the member tried sildenafil or tadalafil?
   ☐ Yes. Please provide the following information.*
   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.
   _____
   ☐ No. Does the member have a contraindication to sildenafil or tadalafil? Please explain.
   _____

Section IV. Please also complete for Orenitram, treprostinil injection, Tyvaso for PAH, and Ventavis requests.

Has the member tried epoprostenol?

☐ Yes. Please provide the following information.*
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. Does the member have a contraindication to epoprostenol? Please explain.
_____

Section V. Please also complete for epoprostenol [Veletri] requests.

Please provide clinical rationale for not using epoprostenol (generic Flolan).
_____

Section VI. Please also complete for sildenafil oral suspension requests.

Please provide clinical rationale for not using sildenafil tablets.
_____

* Please attach a letter documenting additional trials as necessary.

over

Section VII. Please also complete for bosentan for suspension requests.

Member's current weight _____ Date _____

Section VIII. 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 _____