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

Oral Respiratory 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

Leukotrienes

☐ montelukast granules ☐ zafirlukast ☐ zileuton extended-release ☐ Zyflo (zileuton)

Other

☐ Daliresp (roflumilast) ☐ Esbriet (pirfenidone) ☐ Ofev (nintedanib)

Dose and frequency of medication requested _____

Indication (Check all that apply.)

☐ Allergic Rhinitis (montelukast only)
☐ Asthma
☐ Chronic Obstructive Pulmonary Disease (Daliresp only)
☐ Chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype
☐ Exercise-Induced Bronchospasm
☐ Idiopathic Pulmonary Fibrosis
☐ Systemic sclerosis-associated interstitial lung disease (SSc-ILD)
☐ Other _____

Please list all other medications currently prescribed for the member for this indication.

_____

Section I. Please complete for montelukast granule requests.

1. Has the member had a trial with montelukast chewable tablet?.
   ☐ Yes. Please list the drug names, dates/duration of trials, and outcomes below.*
   ☐ No. Please describe why montelukast chewable tablet is not appropriate for this member.

   _____
2. For the diagnosis of allergic rhinitis, has the member had a trial with an intranasal antihistamine or intranasal corticosteroid and one oral second-generation antihistamines (e.g., cetirizine, loratadine)?
   ☐ Yes. Please list the drug names, dates/duration of trials, and outcomes below.*
   ☐ No. Please describe why intranasal antihistamines and corticosteroids, and oral second-generation antihistamines are not appropriate for this member.

   _____

3. For the diagnosis of exercise-induced bronchospasm, has the member had a trial with inhaled albuterol or levalbuterol?
   ☐ Yes. Please list the drug names, dates/duration of trials, and outcomes below.*
   ☐ No. Please describe why inhaled albuterol or levalbuterol is not appropriate for this member.

   _____

   Please provide details for the previous trials.
   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, 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, 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, or other.

   _____

**Please attach a letter documenting additional trials as necessary.*

Section II. Please complete for Daliresp requests.

1. Has the member had a trial with a long-acting bronchodilator (e.g., long-acting beta-agonist, long-acting anticholinergic) within the past four months?
   ☐ 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, or other.

   _____

   ☐ No. Please describe why long-acting bronchodilators are not appropriate for this member.

   _____

2. Has the member had a trial with an inhaled corticosteroid within the past four months?
   ☐ 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, or other.

   _____

   ☐ No. Please describe why inhaled corticosteroids are not appropriate for this member.

   _____

**Please attach a letter documenting additional trials as necessary.*

Section III. Please complete for zileuton extended-release and Zyflo requests.

1. Has the member had a trial with montelukast or zafirlukast?
   ☐ 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, or other.

   _____

   ☐ No. Please describe why montelukast and zafirlukast are not appropriate for this member.

   _____

over

2. For requests for zileuton extended-release, has the member had a trial with Zyflo?
   ☐ Yes. Please describe the dates/duration of trial and outcomes below*.
   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, or other.
   _____
   ☐ No. Please describe why Zyflo is not appropriate for this member.
   _____

**Please attach a letter documenting additional trials as necessary.*

Section IV. Please complete for Ofev requests for a diagnosis of SSc-ILD.

Has the member had a trial with cyclophosphamide or mycophenolate?

☐ 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, or other.
_____

☐ No. Please describe why cyclophosphamide and mycophenolate are not appropriate for this member.
_____

**Please attach a letter documenting additional trials as necessary*

Section V. 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 product 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 _____