



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

## Breast Cancer 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](http://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

- |   |   |
|---|---|
| <input type="checkbox"/> Enhertu (fam-trastuzumab deruxtecan-nxki)              | <input type="checkbox"/> Kisqali-Femara Co-Pack (ribociclib/letrozole)      |
| <input type="checkbox"/> everolimus 2.5 mg, 5 mg, 7.5 mg, 10 mg                 | <input type="checkbox"/> Margenza (margetuximab-cmkb)                       |
| <input type="checkbox"/> everolimus tablets for oral suspension                 | <input type="checkbox"/> Nerlynx (neratinib)                                |
| <input type="checkbox"/> fulvestrant  | <input type="checkbox"/> Ogivri (trastuzumab-dkst)                          |
| <input type="checkbox"/> Halaven (eribulin)                                     | <input type="checkbox"/> Ontruzant (trastuzumab-dttb)                       |
| <input type="checkbox"/> Herceptin (trastuzumab)                                | <input type="checkbox"/> Perjeta (pertuzumab)                               |
| <input type="checkbox"/> Herceptin Hylecta (trastuzumab-hyaluronidase-<br>oysk) | <input type="checkbox"/> Phesgo (pertuzumab/trastuzumab/hyaluronidase-zzxf) |
| <input type="checkbox"/> Herzuma (trastuzumab-pkrb)                             | <input type="checkbox"/> Piqray (alpelisib)                                 |
| <input type="checkbox"/> Ibrance (palbociclib)                                  | <input type="checkbox"/> Trazimera (trastuzumab-qyyp)                       |
| <input type="checkbox"/> Kadcylla (ado-trastuzumab)                             | <input type="checkbox"/> Trodelvy (sacituzumab govitecan-hziy)              |
| <input type="checkbox"/> Kanjinti (trastuzumab-anns)                            | <input type="checkbox"/> Tukysa (tucatinib)                                 |
| <input type="checkbox"/> Kisqali (ribociclib)                                   | <input type="checkbox"/> Verzenio (abemaciclib)                             |

#### Dose, frequency, and duration of medication requested \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Date \_\_\_\_\_

Please indicate prescriber specialty below.

Oncology  Other \_\_\_\_\_

Will the requested agent be used as monotherapy for this indication?  Yes  No

If no, please list all other medications currently prescribed for the member that will be used concomitantly for this indication.

\_\_\_\_\_  
 \_\_\_\_\_

Will the requested agent be used as adjuvant or neoadjuvant therapy for this indication?  Yes  No

If yes, please describe.  Adjuvant  Neoadjuvant

Please indicate billing preference.  Pharmacy  Prescriber in-office  Hospital outpatient

For hospital outpatient billing, provide department-specific facility NPI \_\_\_\_\_

Drug NDC (if known) or service code \_\_\_\_\_

**Indication** (Check all that apply.)

**Breast cancer**

Early  Advanced  Metastatic  Recurrent  Unresectable

**Other Oncologic Indications**

Liposarcoma

Locally advanced or metastatic urothelial cancer

Metastatic gastric or gastroesophageal junction (GEJ) adenocarcinoma

Please describe pertinent mutations if applicable.

ER-positive  ER-negative  HER2-positive  HER2-negative  HR-positive  HR-negative

Other \_\_\_\_\_

Please describe the stage and severity of disease.

Has the member had persistent or recurring disease following surgery and/or radiation therapy?  Yes  No

Is the member a candidate for surgery and/or radiation?

Yes  No. Please describe. \_\_\_\_\_

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**Section I. Please complete for all requests.**

Please list any other prior trials. Please list the drug names, dates/duration of use 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.

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.

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**Section II. Please complete for requests for agents with a preferred alternative.**

Please describe clinical rationale for use of the requested agent instead of the preferred alternative.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Section III. Please complete for requests for quantities above quantity limits.**

Please describe the clinical rationale for exceeding the quantity limit, including a detailed treatment plan.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Section IV. Please include any other pertinent information (if needed).**

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**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*

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**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 \_\_\_\_\_