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

Beta Thalassemia, Myelodysplastic Syndrome, and Sickle Cell Disease 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

☐ Adakveo (crizanlizumab-tmca)
☐ Endari (l-glutamine)
☐ Oxbryta (voxelotor)
☐ Reblozyl (luspatercept-aamt)
☐ Siklos (hydroxyurea tablet)

Dose, frequency, and duration of medication requested _____

Indication (Check all that apply.)

☐ Beta Thalassemia (provide documentation of genetic testing)
☐ Myelodysplastic syndromes with ring sideroblasts or myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis
☐ Sickle Cell Disease
☐ Other _____

Is the prescriber a hematologist?

☐ Yes
☐ No. Please attach consultation notes from a hematologist addressing the use of the requested agent.

Member's current weight _____ Date _____

Section I. Please complete for Adakveo and Oxbryta requests.

1. Has the member experienced sickle cell crises in the last 12 months (two or more for Adakveo and at least one or more for Oxbryta)?
   ☐ Yes. Please provide dates. _____ ☐ No
2. Has the member had an inadequate response to hydroxyurea for at least three months? Please note: Trial will be evaluated to ensure titration to maximally tolerated dose.*
   ☐ Yes. Please note: Requests will be evaluated taking into account MassHealth pharmacy claims history or additional documentation addressing adherence to this agent.
   Dose and frequency _____ Dates of use _____ Outcome _____

Please attach hematologic laboratory data (e.g., absolute neutrophil count [ANC], platelet count, hemoglobin, reticulocyte count) supporting dosing regimen.

☐ No

3. Has the member tried hydroxyurea and had an adverse reaction or does the member have a contraindication to this agent?*
   ☐ Yes. Please explain. _____ ☐ No
4. For Oxbryta requests, please document current hemoglobin (Hb). _____ Date Hb obtained _____
5. For Oxbryta 300 mg tablet for oral suspension requests, please document medical necessity for the requested formulation.

   _____
6. For Adakveo recertification requests, please attach medical records documenting positive response to therapy (e.g., follow up information on vasoocclusive crises, pain management, hospitalizations, and/or member's improvement).
7. For Oxbryta recertification requests, please attach medical records documenting positive response to therapy (e.g., follow up information on vasoocclusive crises, Hb level, laboratory markers associated with hemolysis, and/or member's improvement).

Section II. Please complete for Endari requests.

1. Has the member experienced two or more sickle cell crises in the last 12 months?
   ☐ Yes. Please provide dates. _____ ☐ No
2. Has the member had a trial with hydroxyurea?*
   ☐ Yes. Please list the dates/duration of use and outcomes below.
   Dates/duration of use _____ ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.

   _____
   ☐ No. Please explain why not. _____

Section III. Please complete for Reblozyl for Beta-thalassemia requests.

1. Please attach a copy of genetic test confirming diagnosis of beta thalassemia.
2. Is the member transfusion-dependent?
   ☐ Yes. Please attach medical records supporting regular blood transfusions and/or chronic iron chelator use.
   ☐ No
3. For recertification requests, please attach medical records documenting positive response to therapy (e.g., follow up information on transfusion requirements and/or member's improvement).

Section IV. Please complete for Reblozyl for Myelodysplastic syndromes with ring sideroblasts or myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis requests.

1. Has the member had a trial with an erythropoiesis stimulating agent?*
   ☐ Yes. Please list the outcomes below.
   ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.

   _____
   ☐ No. Please explain why not. _____
2. Has the member required RBC transfusions in the past eight weeks?
   ☐ Yes ☐ No

over

Section V. Please complete for Siklos requests.

Please document medical necessity for the use of tablet formulation.

_____

Section VI. 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 _____