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

Multiple Myeloma 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

☐ Blenrep (belantamab mafodotin-blmf)
☐ Darzalex (daratumumab)
☐ Darzalex Faspro (daratumumab-hyaluronidase-fihj)
☐ Empliciti (elotuzumab)
☐ Kyprolis (carfilzomib)
☐ Ninlaro (ixazomib)
☐ Pomalyst (pomalidomide)
☐ Sarclisa (isatuximab-irfc)
☐ Xpovio (selinexor)

Dose, frequency, and duration of medication requested _____

Height _____ Weight _____ Date _____

Please indicate prescriber specialty: ☐ Hematology ☐ 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.

_____

_____

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.)

☐ **Multiple myeloma**

Other Oncologic Indications

☐ Diffuse large B-cell lymphoma (DLBCL)
☐ Light chain amyloidosis
☐ Kaposi sarcoma
  ☐ Acquired Immunodeficiency Syndrome (AIDS) and failed highly active antiretroviral therapy
  ☐ Negative for Human Immunodeficiency Virus (HIV)

Please describe the stage and severity of disease.

____

Is the cancer metastatic? ☐ Yes ☐ No

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. ____

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.
____

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 Blenrep, and Xpovio for monotherapy requests.

1. Has the member received at least four prior chemotherapy regimens? ☐ Yes. Complete Section I. ☐ No
2. Is the member's disease refractory to at least one proteasome inhibitor (for Blenrep requests) or two proteasome inhibitors (for Xpovio requests), or does the member have a contraindication to proteasome inhibitors? ☐ Yes. Complete Section I. ☐ No
3. Is the member's disease refractory to at least one immunomodulatory agent (for Blenrep requests) or two immunomodulatory agents (for Xpovio requests), or does the member have a contraindication to immunomodulatory agents? ☐ Yes. Complete Section I. ☐ No
4. Is the member's disease refractory to at least one anti-CD38 monoclonal antibody, or does the member have a contraindication to anti-CD38 monoclonal antibodies? ☐ Yes. Complete Section I. ☐ No

Section III. 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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____
____

over

Section IV. Please complete for requests for quantities above quantity limits.

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

_____

_____

_____

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

_____

_____

_____

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 _____