



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

## Lung 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"/> Alecensa (alectinib)    | <input type="checkbox"/> Rybrevant (amivantamab-vmjw) |
| <input type="checkbox"/> Alunbrig (brigatinib)   | <input type="checkbox"/> Tabrecta (capmatinib)        |
| <input type="checkbox"/> erlotinib               | <input type="checkbox"/> Tagrisso (osimertinib)       |
| <input type="checkbox"/> Exkivity (mobocertinib) | <input type="checkbox"/> Tepmetko (tepotinib)         |
| <input type="checkbox"/> Gilotrif (afatinib)     | <input type="checkbox"/> Vizimpro (dacomitinib)       |
| <input type="checkbox"/> Iressa (gefitinib)      | <input type="checkbox"/> Xalkori (crizotinib)         |
| <input type="checkbox"/> Lorbrina (lorlatinib)   | <input type="checkbox"/> Zepzelca (lurbinectedin)     |
| <input type="checkbox"/> Lumakras (sotorasib)    | <input type="checkbox"/> Zykadia (ceritinib)          |
| <input type="checkbox"/> Portrazza (necitumumab) |   |

#### 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.

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

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.)

**Lung cancer**

- Non-small cell lung cancer (NSCLC)
  - Adjuvant treatment for stage IB to IIIA
  - Advanced or metastatic

- Small-cell lung cancer (SCLC)
  - Advanced or metastatic

**Other Oncologic Indications**

- Pancreatic cancer
  - Advanced or metastatic
- Systemic anaplastic large cell lymphoma

Please describe pertinent mutations.

- ALK-positive
  - EGFR
  - KRAS G12C
  - MET exon 14 skipping
  - ROS1
  - T790M resistance
- Please describe details of pertinent mutations including exon deletions or mutations below.

\_\_\_\_\_

Please describe the cell histology, if applicable.

\_\_\_\_\_

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.

\_\_\_\_\_

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 Portrazza requests.**

Please describe medical necessity for the requested agent instead of all other clinically appropriate alternatives.

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\_\_\_\_\_

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**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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**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.

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**Section V. 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 \_\_\_\_\_