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

Targeted Immunomodulators 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

Anti-TNFs
- ☐ Avsola (infliximab-axxq)
- ☐ Cimzia (certolizumab)
- ☐ Enbrel (etanercept)
- ☐ Humira (adalimumab)
- ☐ Inflectra (infliximab-dyyb)
- ☐ infliximab, unbranded
- ☐ Remicade (infliximab)
- ☐ Renflexis (infliximab-abda)
- ☐ Simponi (golimumab)
- ☐ Simponi Aria (golimumab for infusion)

Interleukin Antagonists
- ☐ Actemra (tocilizumab)
- ☐ Adbry (tralokinumab-ldrm)
- ☐ Arcalyst (rilonacept)
- ☐ Cosentyx (secukinumab)
- ☐ Ilaris (canakinumab)
- ☐ Ilumya (tildrakizumab-asmn)
- ☐ Kevzara (sarilumab)
- ☐ Kineret (anakinra)
- ☐ Siliq (brodalumab)
- ☐ Skyrizi (risankizumab-rzaa)
- ☐ Stelara (ustekinumab)
- ☐ Taltz (ixekizumab)
- ☐ Tremfya (guselkumab)

Oral Janus Kinase Inhibitors
- ☐ Cibinqo (abrocitinib)
- ☐ Olumiant (baricitinib)
- ☐ Rinvoq (upadacitinib)
- ☐ Xeljanz (tofacitinib)
- ☐ Xeljanz XR (tofacitinib extended-release)

Miscellaneous Agents
- ☐ Entyvio (vedolizumab)
- ☐ Orencia (abatacept)
- ☐ Otezla (apremilast)

Dose, frequency, and duration of medication requested _____

Indication (Check all that apply.)
- ☐ Acute graft versus host disease (aGVHD) prophylaxis
- ☐ Adult-onset Still's disease (AOSD)
- ☐ Ankylosing spondylitis (AS)
- ☐ Atopic dermatitis
- ☐ Crohn's disease
  - ☐ Fistulizing Crohn's disease
- ☐ Cytokine release syndrome
- ☐ Deficiency of interleukin-1 receptor antagonist (DIRA)
- ☐ Enthesitis-related arthritis (ERA)
- ☐ Familial cold autoinflammatory syndrome (FCAS)
- ☐ Familial Mediterranean fever
- ☐ Giant cell arteritis (GCA)
- ☐ Hidradenitis suppurativa (HS) (Hurley Stage II or III)
- ☐ Hyperimmunoglobulin D syndrome (HIDS)/mevalonate kinase deficiency (MKD)
- ☐ Juvenile idiopathic arthritis (JIA)
  - ☐ Polyarticular ☐ Systemic
- ☐ Muckle-Wells syndrome (MWS)
- ☐ Neonatal-onset multisystem inflammatory disease (NOMID)
- ☐ Non-infectious uveitis

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☐ Non-radiographic axial spondyloarthritis (nr-AxSpA)
☐ Oral ulcers associated with Behcet's disease
☐ Plaque psoriasis (PsO)
☐ Psoriatic arthritis (PsA)
☐ Recurrent pericarditis
☐ Rheumatoid arthritis (RA)
☐ Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)
☐ Tumor necrosis factor receptor associated periodic syndrome (TRAPS)
☐ Ulcerative colitis (UC)
☐ Other _____

Please specify severity of indication below.

☐ Mild ☐ Mild-moderate ☐ Moderate ☐ Moderate-severe ☐ Severe

Please complete the following for all requests.

1. Member's current weight _____
2. 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 _____
3. Is the member stabilized on the requested medication? ☐ Yes. Please provide start date. _____ ☐ No

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Section I. Please complete for all requests, except for a diagnosis of aGVHD prophylaxis, atopic dermatitis, AOSD, cytokine release syndrome, DIRA, FCAS, FMF, GCA, HIDS/MKD, HS (Hurley Stage II or III), MWS, NOMID, non-infectious uveitis, nr-AxSpA, oral ulcers associated with Behcet's disease, SSc-ILD, or TRAPS.

Has the member tried traditional or biologic disease modifying antirheumatic drugs (DMARDs)?

☐ Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XII below.*
☐ No. Please explain why not. _____

Section II. Please also complete for treatment of PsO with Avsola, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Inflectra, Otezla, Remicade, Renflexis, Siliq, Skyrizi, Stelara, Taltz, Tremfya, or unbranded infliximab.

Has the member tried other therapies to treat this condition including topical agents, systemic agents, and phototherapy?

☐ Yes. Please list the names of the therapies, dates/duration of trials, and outcomes in Section XII below.*
☐ No. Please explain why not. _____

Section III. Please also complete for treatment of AS with anti-TNFs, Cosentyx, Taltz, Xeljanz, and Xeljanz XR, and for treatment of nr-AxSpA with Cimzia, Cosentyx, and Taltz.

1. Has the member tried two nonsteroidal anti-inflammatory drugs (NSAIDs)?
   ☐ Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XII below.*
   ☐ No. Please explain why not. _____
2. If the request is for Cosentyx,Taltz, Xeljanz, or Xeljanz XR, has the member tried one anti-TNF agent that is FDA-approved for the requested indication?
   ☐ Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XII below.*
   ☐ No. Please explain why not. _____

Section IV. Please complete for treatment of non-infectious uveitis with Humira and for treatment of GCA with Actemra.

Has the member tried other medications to treat this condition including glucocorticoid therapy for Actemra, or glucocorticoid and immunosuppressive therapy for Humira?

☐ Yes. Please list the drug name, dates/duration of trials, and outcomes in Section XII below.*
☐ No. Please explain why not. _____

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Section V. Please complete for treatment of cytokine release syndrome with Actemra IV.

Please provide anticipated date of administration with concurrent CAR T-cell therapy. _____

Section VI. Please complete for treatment of SSc-ILD with Actemra SC.

Has the member tried cyclophosphamide or mycophenolate?

☐ Yes. Please list the drug name, dates/duration of trials, and outcomes in Section XII below.*

☐ No. Please explain why not. _____

Section VII. Please complete for treatment of DIRA with Arcalyst and Kineret.

1. Has the diagnosis been confirmed through genetic testing? ☐ Yes. ☐ No.
2. If the request is for Arcalyst, has the member tried Kineret?
   ☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XII below.*
   ☐ No. Please explain why not. _____

Section VIII. Please complete for treatment FCAS and MWS with Arcalyst and Ilaris and for treatment of FMF, HIDS/MKD, and TRAPS with Ilaris.

1. Has the diagnosis been confirmed through genetic testing? ☐ Yes. ☐ No.
   If no, does the member have evidence of symptoms indicative of the disease?
   ☐ Yes. Please explain. _____
   ☐ No.
2. If the request is for treatment of FCAS and MWS with Arcalyst, has the member tried Ilaris?
   ☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XII below.*
   ☐ No. Please explain why not. _____
3. If the request is for treatment of FMF with Ilaris, has the member tried colchicine?
   ☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XII below.*
   ☐ No. Please explain why not. _____

Section IX. Please complete for treatment of AOSD and systemic JIA with Ilaris, and for treatment of recurrent pericarditis with Arcalyst.

1. Has the member tried corticosteroids?
   ☐ Yes. Please list the drug name, dates/duration of trials, and outcomes in Section XII below.*
   ☐ No. Please explain why not. _____
2. Has the member tried Kineret?
   ☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XII below.*
   ☐ No. Please explain why not. _____
3. If the request is for treatment of recurrent pericarditis with Arcalyst, has the member tried NSAIDs or aspirin?
   ☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XII below.*
   ☐ No. Please explain why not. _____
4. If the request is for treatment of recurrent pericarditis with Arcalyst, has the member tried colchicine?
   ☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XII below.*
   ☐ No. Please explain why not. _____

Section X. Please complete for aGVHD prophylaxis with Orencia.

1. Will the requested agent be used in combination with a calcineurin inhibitor?
   ☐ Yes. Please list drug name and dose and frequency below.
   Drug name _____ Dose and frequency _____
   ☐ No. Please explain. _____

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2. Will the requested agent be used in combination with methotrexate?
   ☐ Yes. Please list dose and frequency. ____________________
   ☐ No. Please explain. ____________________

Section XI. Please complete for treatment of atopic dermatitis with Adbry, Cibinqo, and Rinvoq.

1. Is the prescriber a specialist (i.e., allergist/immunologist or dermatologist)?
   ☐ Yes
   ☐ No. If no, please attach consultation notes from a specialist addressing the use of the requested agent.
2. Has the member tried a superpotent or potent topical corticosteroid to treat this condition?
   ☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XII below.*
   ☐ No. Please explain why not. ____________________
3. Has the member tried topical tacrolimus or Eucrisa to treat this condition?
   ☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XII below.*
   ☐ No. Please explain why not. ____________________
4. For Cibinqo and Rinvoq, has the member tried Dupixent to treat this condition?
   ☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XII below.*
   ☐ No. Please explain why not. ____________________

Section XII. Please complete for all requests as needed.

Please provide the following information regarding previous trials.*

Drug name/Therapy ____________________ Dates/duration of use ____________________
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response
Briefly describe details of adverse reaction or inadequate response.
____

Drug name/Therapy ____________________ Dates/duration of use ____________________
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response
Briefly describe details of adverse reaction or inadequate response.
____

Drug name/Therapy ____________________ Dates/duration of use ____________________
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response
Briefly describe details of adverse reaction or inadequate response.
____

Drug name/Therapy ____________________ Dates/duration of use ____________________
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response
Briefly describe details of adverse reaction or inadequate response.
____

Drug name/Therapy ____________________ Dates/duration of use ____________________
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response
Briefly describe details of adverse reaction or inadequate response.
____

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

Please describe the clinical rationale for exceeding the quantity limit.
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Section XIV. 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.

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

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 _____