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

Asthma/Allergy Monoclonal Antibodies 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

☐ Cinqair (reslizumab) ☐ Dupixent (dupilumab) ☐ Fasenra (benralizumab)
☐ Nucala (mepolizumab) ☐ Xolair (omalizumab) ☐ Tezspire (tezepelumab-ekko)

Dose, frequency, and duration of medication requested _____

☐ Naïve to therapy ☐ Continuation of therapy

Indication (Check all that apply.)

☐ Chronic idiopathic urticaria
☐ Nasal polyps
☐ Eosinophilic granulomatosis with polyangiitis
☐ Hypereosinophilic syndrome
☐ Moderate-to-severe allergy-related asthma
☐ Moderate-to-severe eosinophilic asthma
☐ Moderate-to-severe atopic dermatitis
☐ Oral corticosteroid-dependent asthma
☐ Severe asthma
☐ Other (Please indicate.) _____

Please complete the following for all requests.

1. Member's current weight _____ Date _____
2. Please indicate prescriber specialty. ☐ Allergy & immunology ☐ Dermatology ☐ Otolaryngology ☐ Pulmonology ☐ Other (Please specify.) _____
3. 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 _____
4. Is this member a referral candidate for care coordination? ☐ Yes ☐ No
   If yes, MassHealth will offer care coordination services to this member. Please describe which additional behavioral health services would be beneficial.
   _____

Section I. Please complete for Xolair for the diagnosis of moderate-to-severe allergy-related asthma, for Cinqair, Fasenra, and Nucala for the diagnosis of severe eosinophilic asthma, and for Tezspire for the diagnosis of severe asthma.

For Xolair, please complete questions 1 through 4. For Cinqair, Fasenra, and Nucala, complete questions 3 and 4. For Tezspire, complete question 4.

1. Pretreatment serum IgE level _____ Test date _____
   Does the member have a history of positive skin test or radioallergosorbent test (RAST) to an aeroallergen(s)?
   ☐ Yes. Please list the allergens. _____
   ☐ No
2. For requests for the 150 mg syringe, please provide medical necessity for the requested formulation instead of the vial formulation. _____
3. Does the member have evidence of an eosinophilic phenotype of asthma?
   ☐ Yes. Please explain. _____
   ☐ No
4. Has the member tried other medications to treat this condition [including beta agonists, inhaled and oral corticosteroids, leukotriene modifiers, or combination therapies (LABA/ICS)]?
   ☐ Yes. Please list the drug name, dates/duration of trials 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, contraindication, 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, contraindication, 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, contraindication, or other.
   _____
   ☐ No. Please explain why not. _____

Section II. Please complete for Xolair requests for the diagnosis of chronic idiopathic urticaria.

1. Has the member tried two different histamine$_1$ antihistamines?
   ☐ Yes. Please list the drug name, dates/duration of trials 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, contraindication, 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, contraindication, or other.
   _____
   ☐ No. Please describe why histamine$_1$ antihistamines are not appropriate for this member.
   _____
2. Has the member tried a histamine$_2$ antihistamine?
   ☐ Yes. Please list the drug name, dates/duration of trials and outcomes below.*
   Drug name _____ Dates/duration of use _____

over

Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

_____

☐ No. Please describe why histamine$_2$ antihistamines are not appropriate for this member.

_____

3. For requests for the 150 mg syringe, please provide medical necessity for the requested formulation instead of the vial formulation. _____

Section III. Please complete for Nucala requests for the diagnosis of eosinophilic granulomatosis with polyangiitis.

1. Has the member tried a systemic glucocorticoid?
   ☐ Yes. Please list the drug name, dates/duration of trials 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, contraindication, or other.

   _____

   ☐ No. Please describe why systemic glucocorticoids are not appropriate for this member.

   _____
2. Has the member tried azathioprine or methotrexate?
   ☐ Yes. Please list the drug name, dates/duration of trials 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, contraindication, or other.

   _____

   ☐ No. Please describe why azathioprine and methotrexate are not appropriate for this member.

   _____

Section IV. Please complete for Nucala requests for hypereosinophilic syndrome.

1. Has a non-hematologic secondary cause been excluded? ☐ Yes ☐ No
2. Has the member tried a systemic glucocorticoid?
   ☐ Yes. Please list the drug name, dates/duration of trials 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, contraindication, or other.

   _____

   ☐ No. Please describe why systemic glucocorticoids are not appropriate for this member.

   _____
3. Has the member tried hydroxyurea, interferon alfa, or methotrexate?
   ☐ Yes. Please list the drug name, dates/duration of trials 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, contraindication, or other.

   _____

   ☐ No. Please describe why hydroxyurea, interferon alfa, and methotrexate are not appropriate for this member.

   _____

Section V. Please complete for Dupixent requests for moderate-to-severe atopic dermatitis.

1. Has the member tried a superpotent or potent topical corticosteroid to treat this condition?
   ☐ Yes. Please list the drug name, dates/duration of trials and outcome below.*

over

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, contraindication, or other.

_____

☐ No. Please describe why a superpotent or potent topical corticosteroid is not appropriate for this member.

_____

2. Has the member tried topical tacrolimus or Eucrisa to treat this condition?
   ☐ Yes. Please list the dates/duration of trial and outcome.*
   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, contraindication, or other.

   _____

   ☐ No. Please describe why topical tacrolimus and Eucrisa are not appropriate for this member.

   _____

Section VI. Please complete for Dupixent requests for moderate-to-severe eosinophilic asthma and oral corticosteroid-dependent asthma.

For requests for oral corticosteroid-dependent asthma, only question 1 is required.

1. Has the member tried other medications to treat this condition (including combination inhaler, combination of an inhaled corticosteroid and a long-acting beta agonist inhaler or chronic oral corticosteroids)?
   ☐ Yes. Please list the drug names, dates/duration of trials 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, contraindication, 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, contraindication, or other.

   _____

   ☐ No. Please describe why other medications are not appropriate for this member.

   _____

2. Does the member have evidence of an eosinophilic phenotype of asthma?
   ☐ Yes. Please explain. _____
   ☐ No

Section VII. Please complete for Dupixent, Nucala, and Xolair requests for nasal polyps.

1. Has the member tried an oral corticosteroid to treat this condition?
   ☐ Yes. Please list the drug name, dates/duration of trials and outcome 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, contraindication, or other.

   _____

   ☐ No. Please describe why oral corticosteroids are not appropriate for this member.

   _____

2. Has the member tried an intranasal corticosteroid to treat this condition?
   ☐ Yes. Please list the drug name, dates/duration of trials and outcome 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, contraindication, or other.

   _____

over

☐ No. Please describe why intranasal corticosteroids are not appropriate for this member.

_____

3. For requests for Dupixent, has the member failed a prior nasal surgery? ☐ Yes ☐ No.
4. Will the requested agent be used as adjunctive therapy?
   ☐ Yes
   ☐ No. Please describe why not. _____
5. For requests for Xolair 150 mg syringe, please provide medical necessity for the requested formulation instead of the vial formulation. _____

Section VIII. Please complete for Dupixent requests for eosinophilic esophagitis.

1. Has the member tried a proton pump inhibitor to treat this condition?
   ☐ Yes. Please list the drug name, dates/duration of trials and outcome 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, contraindication, or other.

   _____

   ☐ No. Please describe why proton pump inhibitors are not appropriate for this member.

   _____
2. Has the member tried budesonide or fluticasone propionate to treat this condition?
   ☐ Yes. Please list the drug name, dates/duration of trials and outcome 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, contraindication, or other.

   _____

   ☐ No. Please describe why budesonide and fluticasone propionate are not appropriate for this member.

   _____

** 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 _____