



Prior Authorization Request Administrative Information

Member information

Last name _____ First name _____ MI _____

Member ID _____ Date of birth _____

Sex assigned at birth ☐ Female ☐ Male ☐ "X" or Intersex

Current gender ☐ Female ☐ Male ☐ Transgender male ☐ Transgender female ☐ Other _____

Place of residence ☐ Home ☐ Nursing facility ☐ Other _____

Race/ethnicity _____ Preferred spoken language _____ Preferred written language _____

MassHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, creed, sexual orientation, or sex (including gender identity and gender stereotyping).

Plan Contact Information

Please indicate the member's MassHealth Plan and fax or submit this completed and signed form according to the Plan's contact information below.

MassHealth Fee-For-Service (FFS) Plan, Primary Care Clinician (PCC) Plan, Primary Care Accountable Care Organization (PCACO) Plan, Children's Medical Security Plan, and Health Safety Net Plan

☐ **MassHealth Drug Utilization Review Program**

Pharmacy: Fax: (877) 208-7428 - Tel: (800) 745-7318

MassHealth Managed Care Organization (MCO) and Accountable Care Partnership Plans (ACPP)

☐ **Fallon Health**

Online Prior Authorization: go.covermymeds.com/OptumRx

Online Prior Authorization: providerportal.surescripts.net/ProviderPortal/optum

Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033

☐ **Health New England**

Online Prior Authorization: go.covermymeds.com/OptumRx

Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545

☐ **Mass General Brigham Health Plan**

Online Prior Authorization: provider.massgeneralbrighamhealthplan.org

Pharmacy: Fax: (866) 255-7569 - Tel: (877) 433-7643

☐ **Tufts Health Plan**

Online Prior Authorization: point32health.promptpa.com

Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985

☐ **WellSense Health Plan**

Online Prior Authorization: wellsense.org/providers/ma/pharmacy/prior-authorizations

Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822

Antiretroviral 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.

Medication information

Antiretroviral requested

- | | |
|----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Apretude (cabotegravir injection) | <input type="checkbox"/> Rukobia (fostemsavir) |
| <input type="checkbox"/> Cimduo (lamivudine/tenofovir disoproxil fumarate) | <input type="checkbox"/> Temixys (lamivudine/tenofovir disoproxil fumarate) |
| <input type="checkbox"/> efavirenz/lamivudine/tenofovir disoproxil fumarate (600 mg/300 mg/300 mg) | <input type="checkbox"/> tenofovir disoproxil fumarate tablet > 1 unit/day |
| <input type="checkbox"/> efavirenz/lamivudine/tenofovir disoproxil fumarate (400 mg/300 mg/300 mg) | <input type="checkbox"/> Tivicay (dolutegravir) > 1 unit/day |
| <input type="checkbox"/> maraviroc | <input type="checkbox"/> Trogarzo (ibalizumab-uiyk) |
| <input type="checkbox"/> nevirapine extended-release | <input type="checkbox"/> Viread (tenofovir disoproxil fumarate) powder ≥ 13 years of age |

Dose, frequency, and duration of medication requested

Indication (Check all that apply or include ICD-10 code, if applicable.)

- ☐ HIV-1 Current viral load and date _____
- ☐ pre-exposure prophylaxis (PreEP)
- ☐ Chronic Hepatitis B ☐ Other (specify) _____

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 requests for tenofovir disoproxil fumarate tablet > 1 unit/day, and Viread powder ≥ 13 years of age.

Please describe the medical necessity for the agent selected. Please address need for the requested quantity (tenofovir disoproxil fumarate tablet), or use in the requested age group (Viread powder), as appropriate.

Section II. Please complete for Tivicay requests > 1 unit/day.

- Will the member be taking the requested medication concurrently with carbamazepine, efavirenz, fosamprenavir/ritonavir, Aptivus (tipranavir)/ritonavir, or rifampin?
☐ Yes. Please document drug name with dose and frequency. ☐ No
Drug _____ Dose and Frequency _____
- Does the member have integrase strand transfer inhibitor (INSTI)-associated resistance substitutions or clinically suspected INSTI-resistance?
☐ Yes ☐ No

Section III. Please complete for nevirapine extended-release requests.

Please attach medical records documenting an inadequate response or adverse reaction to nevirapine immediate-release formulation.

Section IV. Please complete for Cimduo, efavirenz/lamivudine/tenofovir disoproxil fumarate, and Temixys requests.

1. Does the member experience any of the following? (Check all that apply.)
☐ Yes
☐ Significant psychiatric diagnosis leading to documented difficulty with adherence.
Please document diagnosis. _____
☐ Homelessness and difficulty storing larger amounts of medications.
☐ Difficulty with adherence leading to complications.
☐ Developmental issues without adequate support to properly manage their own HIV regimen.
☐ No. Please provide medical necessity for use of the combination product instead of the commercially available separate agents. _____

2. For members < 18 years of age, please provide member's current weight. _____
3. For Cimduo and Temixys, will the member be taking the requested medication concurrently with at least one other antiretroviral?
☐ Yes. Please document drug name with dose and frequency. ☐ No
Drug _____ Dose and Frequency _____

Section V. Please complete for Rukobia requests.

1. Is the member antiretroviral-experienced with documented historical or baseline resistance, intolerability, and/or contraindication to antiretroviral?
☐ Yes. Please document drug name and outcome.* ☐ No
Drug _____ ☐ Intolerability ☐ Resistant ☐ Other
Briefly describe details of intolerability, resistance, or other. _____
2. Has the member failed current antiretroviral regimen due to resistance, intolerance, or safety considerations?
☐ Yes. Please document drug name and outcome.* ☐ No
Drug _____ ☐ Intolerability ☐ Resistant ☐ Other
Briefly describe details of intolerability, resistance, or other. _____
3. Will the member be taking the requested medication concurrently with at least one other antiretroviral?
☐ Yes. Please document drug name with dose and frequency. ☐ No
Drug _____ Dose and Frequency _____

Section VI. Please complete for Trogarzo requests.

1. Does the member have resistance to one agent from each of the three classes of antiretrovirals [nucleoside analog reverse transcriptase inhibitor (NRTI), non-nucleoside reverse transcriptase inhibitor (NNRTI), protease inhibitor (PI)]?
☐ Yes. Please document drug names and outcomes.* ☐ No
NRTI _____ ☐ Resistant ☐ Other
NNRTI _____ ☐ Resistant ☐ Other
PI _____ ☐ Resistant ☐ Other
Briefly describe details of resistance or other. _____

2. Will the member be taking the requested medication concurrently with at least one other antiretroviral?

☐ Yes. Please document drug name with dose and frequency. ☐ No

Drug _____ Dose and Frequency _____

Section VII. Please complete for Apretude requests.

1. Please provide member's current weight. _____
2. Is the member HIV-negative? ☐ Yes ☐ No
3. Is the member considered at risk for acquiring HIV infection? ☐ Yes ☐ No
4. Please provide clinical rationale for use instead of emtricitabine/tenofovir disoproxil fumarate.

5. Please provide clinical rationale for use instead of Descovy.

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

Please continue to next page and complete Prescriber and Provider Information section.

Prior Authorization Request Prescriber and Provider Information

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

Please also complete for professionally administered medications, if applicable.

Start date _____ End date _____
Servicing prescriber/facility name _____ ☐ Same as prescribing provider
Servicing provider/facility address _____
Servicing provider NPI/tax ID No. _____
Name of billing provider _____
Billing provider NPI No. _____
Is this a request for recertification? ☐ Yes ☐ No
CPT code _____ No. of visits _____ J code _____ No. of units _____

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 _____