Print Clear

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 (Non-Specialty Drugs): go.covermymeds.com/OptumRx Online Prior Authorization (Specialty/Medical Drugs): provider.massgeneralbrighamhealthplan.org Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555
☐ **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

over

Anti-Amyloid 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.**

Medication information

Medication requested

☐ Aduhelm (aducanumab-avwa)
☐ Leqembi (lecanemab-irmb)

Dose, frequency, and duration of medication requested

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

☐ Alzheimer's Disease (Specify stage of disease.)

☐ Mild cognitive impairment ☐ Mild dementia ☐ Other

Please indicate billing preference. ☐ Pharmacy ☐ Prescriber in-office ☐ Hospital outpatient
If applicable, please also complete section for professionally administered medications at end of form.

Is the prescriber a specialist in the treatment of dementia or Alzheimer's Disease?
☐ Yes
☐ No. Please attach consultation notes from a specialist in the treatment of dementia or Alzheimer's Disease (e.g., neurologist, geriatric psychiatrist, geriatrician who specializes in treating dementia).

Section I. Please complete for all requests.

For Leqembi requests, please note testing for ApoE ε4 status should be performed prior to initiation of treatment to inform the risk of developing amyloid related imaging abnormalities (ARIA). ApoE ε4 genotyping is covered with prior authorization obtained through the Provider Online Service Center (POSC).

1. Please provide baseline (within the past three months) score of one of the following tests and attach supporting documentation.

   Mini Mental State Exam (MMSE) (Please attach a copy.) Date

   Montreal Cognitive Assessment (MoCA) (Please attach a copy.) Date

   Saint Louis University Mental Status Examination (SLUMS) (Please attach a copy.) Date

2. Does the member have confirmed evidence of clinically significant Alzheimer's Disease (AD) neuropathology based on one of the following? If yes, please attach supporting documentation.
   ☐ Yes, based on Cerebral Spinal Fluid (CSF) biomarkers. Please attach supporting documentation.
   ☐ Yes, based on Amyloid positron emission tomography (PET). Please attach supporting documentation.
   ☐ No

3. Has the member had a brain magnetic resonance imaging (MRI) in the previous 12 months?

   ☐ Yes. Date ☐ No

Section II. Please also complete for Aduhelm requests.

1. Has the member and/or authorized representative been informed of the known and potential risks and lack of established clinical benefit associated with treatment?
   ☐ Yes (Member) ☐ Yes (Authorized Representative) ☐ No
2. Has the member had a trial with Leqembi?
   ☐ Yes. Please list the dates/duration of trials and outcomes below.*
   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.
   ☐ No. Please describe why Leqembi is not appropriate for this member.
3. Does the member have any of the following non-AD neurodegenerative disorders?

Probable dementia with Lewy bodies by consensus criteria	☐ Yes	☐ No
Suspected frontotemporal degeneration	☐ Yes	☐ No
Dementia in Down syndrome	☐ Yes	☐ No

4. Does the member have significant cerebrovascular disease as established by brain MRI showing any of the following? (Check all that apply.)
   ☐ Yes
   - ☐ Acute or sub-acute hemorrhage
   - ☐ Prior macro-hemorrhage or prior subarachnoid hemorrhage (unless finding is not due to an underlying structural or vascular hemorrhage)
   - ☐ Microhemorrhages
     Please provide number.
   - ☐ Cortical infarct
   - ☐ Lacunar infarct
     Please provide number.
   - ☐ Superficial siderosis
   - ☐ History of diffuse white matter disease

   ☐ No
5. Does the member have any of the following cardiovascular conditions?

Uncontrolled hypertension	☐ Yes	☐ No
Coronary artery disease (including unstable angina and myocardial infarction)	☐ Yes	☐ No
Heart failure	☐ Yes	☐ No
Arrhythmia	☐ Yes	☐ No
Clinically significant carotid atherosclerosis and/or peripheral arterial disease	☐ Yes	☐ No
History of stroke (within the past year)	☐ Yes. Date	☐ No
History of transient ischemic attack (within the past year)	☐ Yes. Date	☐ No
History of unexplained loss of consciousness (within the past year)	☐ Yes. Date	☐ No
Coagulopathy	☐ Yes	☐ No
Requirement for therapeutic anticoagulation and/or dual antiplatelet therapy (not including aspirin ≤ 325 mg/day as monotherapy)	☐ Yes	☐ No

over

6. Please indicate if the member has any of the following chronic medical conditions (Check all that apply and please describe.)

☐ Active chronic infection (HIV, HCV)

☐ Anxiety disorder

☐ Autoimmune disease requiring chronic immunosuppression

☐ Diabetes mellitus

☐ Pulmonary disease

☐ Liver disease

☐ Malignant neoplasm

☐ Mood disorder

☐ Psychosis

☐ Seizure disorder

☐ Other clinically significant condition

If the member has any of the above, is the condition(s) controlled?

☐ Yes. Please explain*.

☐ No. Please explain*.

Section III. Please complete for recertification requests. For Aduhelm requests, please complete questions 1 through 6. For Leqembi requests, please complete questions 1 and 2.

1. Has the member had follow-up MRIs completed in accordance with the FDA-approved label?

   ☐ Yes. Please describe.

   ☐ No

2. Please provide most recent score and date administered for one of the following tests, and attach supporting documentation.

   MMSE (Please attach a copy.) Date

   MoCA (Please attach a copy.) Date

   SLUMS (Please attach a copy.) Date

3. Does the member have new incident ARIA-hemosiderin deposition (ARIA-H) microhemorrhages?

   ☐ Yes. Please provide the following information below.

   Please indicate number of new incident microhemorrhage(s).

   Please describe symptoms: ☐ Asymptomatic (no clinical symptoms) ☐ Mild ☐ Moderate ☐ Severe

   Have the member's microhemorrhages been stabilized? ☐ Yes ☐ No

   ☐ No

4. Does the member have new incident ARIA-H areas of superficial siderosis?

   ☐ Yes. Please provide the following information below.

   Please indicate number of new incident areas of superficial siderosis.

   Please describe symptoms: ☐ Asymptomatic (no clinical symptoms) ☐ Mild ☐ Moderate ☐ Severe

   Has the member's superficial siderosis been stabilized? ☐ Yes ☐ No

   ☐ No

over

5. Does the member have ARIA-edema (ARIA-E)?
   ☐ Yes. Please provide the following information below.
   Does the member have new ARIA-E? ☐ Yes ☐ No
   Please describe symptoms: ☐ Asymptomatic (no clinical symptoms) ☐ Mild ☐ Moderate ☐ Severe
   What is the severity of ARIA-E on MRI? ☐ Mild ☐ Moderate ☐ Severe
   Has the member's ARIA-E been stabilized? ☐ Yes ☐ No
   ☐ No
6. Did the member initiate or develop any of the following? (Check all that apply.)
   ☐ Yes
   ☐ Initiation of anticoagulation
   ☐ Development of active immune-mediated/autoimmune conditions (e.g., Crohn's disease, systemic lupus erythematosus, aplastic anemia, myasthenia gravis, meningitis/encephalitis)
   ☐ Initiation of immunomodulatory medications (e.g., cancer immunotherapies, rituximab, azathioprine)
   ☐ Development of other neurologic conditions (e.g., intracerebral bleeds, traumatic brain injury, stroke)
   If yes, please describe clinical rationale for continued treatment*.
   ☐ No

* Please attach a letter documenting additional information as applicable.

Section IV. Please complete and provide documentation for exceptions to Step Therapy.

1. Is the alternative drug required under the step therapy protocol contraindicated, or will likely cause an adverse reaction in, or physical or mental harm to the member? ☐ Yes ☐ No
   If yes, briefly describe details of contraindication, adverse reaction, or harm.
2. Is the alternative drug required under the step therapy protocol expected to be ineffective based on the known clinical characteristics of the member and the known characteristics of the alternative drug regimen?
   ☐ Yes ☐ No
   If yes, briefly describe details of known clinical characteristics of member and alternative drug regimen.
3. Has the member previously tried the alternative drug required under the step therapy protocol, or another alternative drug in the same pharmacologic class or with the same mechanism of action, and such alternative drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?
   ☐ Yes ☐ No
   If yes, please provide details for the previous trial.
   Drug name 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.
4. Is the member stable on the requested prescription drug prescribed by the health care provider, and switching drugs will likely cause an adverse reaction in or physical or mental harm to the member?
   ☐ Yes. Please provide details.
   ☐ No

over

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

Email 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 _____

Printed name of prescribing provider Date

(The form can either be signed by hand and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.)