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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

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Antihistamine 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

Medication requested (Check one or all that apply.)

Intranasal Antihistamines

- ☐ azelastine 0.15% nasal spray
- ☐ olopatadine nasal spray

Single Oral Antihistamines

- ☐ carbinoxamine 6 mg tablet
- ☐ desloratadine orally disintegrating tablet (ODT)
- ☐ desloratadine tablet
- ☐ dexchlorpheniramine solution
- ☐ Karbinal ER (carbinoxamine extended-release)
- ☐ levocetirizine solution

Combination Oral Antihistamines

- ☐ Clarinex-D (desloratadine/pseudoephedrine)

Dose and frequency of medication requested

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

- ☐ Allergic Rhinitis
- ☐ Non-allergic Rhinitis
- ☐ Urticaria
- ☐ Other

Please list all other medications currently prescribed for the member for this indication.

Section I. Please complete for desloratadine ODT and levocetirizine solution requests. Please also complete Section II for these medications.

Does the member have a swallowing disorder or condition affecting swallowing ability?

- ☐ Yes. Please describe.
- ☐ No. Please describe clinical rationale for not using oral tablet formulation.

Section II. Please complete for Clarinex-D, desloratadine ODT, and levocetirizine solution.

Has the member had a trial with an intranasal corticosteroid and two second-generation antihistamines (e.g., cetirizine, levocetirizine, loratadine)?

For requests for combination antihistamines, please include information about trials with second-generation antihistamines in combination with pseudoephedrine (e.g., cetirizine/pseudoephedrine, loratadine/pseudoephedrine).

- ☐ 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, 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.

☐ No. Please describe why intranasal corticosteroids and second-generation antihistamines are not appropriate for this member.

Section III. Please complete for azelastine 0.15% nasal spray and olopatadine nasal spray requests.

1. Has the member had a trial with an intranasal corticosteroid?
   ☐ 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, or other.
   ☐ No. Please describe why intranasal corticosteroids are not appropriate for this member.
2. Has the member had a trial with azelastine 137 mcg nasal spray?
   ☐ 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 azelastine 137 mcg nasal spray is not appropriate for this member.
3. For requests for any agent at a quantity > 1 inhaler/30 days, please document an inadequate response to the manufacturer's recommended dosing.

Section IV. Please complete for carbinoxamine 6 mg tablet and Karbinal ER requests.

1. Has the member had a trial with an intranasal corticosteroid and two non-selective antihistamines?
   ☐ Yes. Please list the drug names, dates/duration of trials, and outcomes below.*
   Drug name Dates/duration of use

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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.

☐ No. Please describe why intranasal corticosteroids and non-selective antihistamines are not appropriate for this member.

2. For carbinoxamine 6 mg tablet requests, has the member had a trial with carbinoxamine 4 mg tablet?
   ☐ 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 carbinoxamine 4 mg tablet is not appropriate for this member.
3. For Karbinal ER requests, has the member had a trial with carbinoxamine immediate-release solution?
   ☐ 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 carbinoxamine immediate-release solution is not appropriate for this member.

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

Section V. Please complete for dexchlorpheniramine solution requests.

Has the member had a trial with two antihistamine solutions that do not require prior authorization?
☐ 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, 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.

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☐ No. Please explain why not.

Section VI. Please complete for desloratadine tablet requests.

Has the member had a trial with cetirizine, fexofenadine, levocetirizine, or loratadine?
☐ 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, or other.

☐ No. Please describe why cetirizine, fexofenadine, levocetirizine, and loratadine are not appropriate for this member.

Section VII. 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

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

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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.)