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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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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

- ☐ Cimduo (lamivudine/tenofovir disoproxil fumarate)
- ☐ efavirenz/lamivudine/tenofovir disoproxil fumarate (600 mg/300 mg/300 mg)
- ☐ efavirenz/lamivudine/tenofovir disoproxil fumarate (400 mg/300 mg/300 mg)
- ☐ maraviroc
- ☐ nevirapine extended-release
- ☐ Rukobia (fostemsavir)
- ☐ Sunlenca (lenacapavir)
- ☐ Temixys (lamivudine/tenofovir disoproxil fumarate)
- ☐ tenofovir disoproxil fumarate tablet > 1 unit/day
- ☐ Tivicay (dolutegravir) > 1 unit/day
- ☐ Trogarzo (ibalizumab-uiyk)
- ☐ 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.

1. 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 _____
2. 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 and Sunlenca 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

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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 _____

3. Has the member tried Rukobia or Sunlenca?
   ☐ Yes. Please describe the outcome. ☐ Adverse reaction ☐ Inadequate response ☐ Other

   Briefly describe the details of adverse reaction, inadequate response, or other.

   ☐ No. Explain why Rukobia and Sunlenca 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.

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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.)