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

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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.**

Medication information

Medication requested

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

Dose, frequency, and duration of medication requested

☐ Naïve to therapy ☐ Continuation of therapy

[MB] *This drug is available through the health care professional who administers the drug or in an outpatient or inpatient hospital setting. MassHealth does not pay for this drug to be dispensed through the retail pharmacy. If listed, prior authorization does not apply through the hospital outpatient and inpatient settings. Please refer to 130 CMR 433.408 for prior authorization requirements for other health care professionals. Notwithstanding the above, this drug may be an exception to the unified pharmacy policy; please refer to respective MassHealth Accountable Care Partnership Plans (ACPPs) and Managed Care Organizations (MCOs) for prior authorization status and criteria, if applicable.*

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

☐ 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
☐ Prurigo nodularis
☐ 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
   If applicable, please also complete section for professionally administered medications at end of form.
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 or autoinjection, 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.

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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 _____
   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 or autoinjection, 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.*

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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.*

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.

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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.

☐ 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 or autoinjection, 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.

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

Section IX. Please complete for Dupixent requests for prurigo nodularis.

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.*
   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 an intralesional 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 intralesional corticosteroids are not appropriate for this member.
3. Has the member tried phototherapy to treat this condition?
   ☐ Yes. Please list the drug name, dates/duration of trials, and outcome 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, contraindication, or other.
   ☐ No. Please describe why phototherapy is not appropriate for this member.

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

Section X. 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.)