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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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Erythropoiesis-Stimulating 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

Drug name requested

Dose, frequency, and duration

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

Drug NDC (if known) or service code

Section I. Please complete for all requests.

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

☐ **Anemia due to chronic renal failure**

Is the member receiving hemodialysis? ☐ Yes ☐ No (Please note, if the member is receiving hemodialysis, contact the dialysis clinic for proper billing procedure.)

Current hemoglobin Date

Glomerular Filtration Rate (GFR)

Have other causes of anemia been ruled out (hemolysis, iron, vitamin B12, and folate deficiency)?
☐ Yes ☐ No. If no, please provide medical necessity for the use of requested agent.

☐ **Anemia post-renal transplant**

Is the member receiving hemodialysis? ☐ Yes ☐ No (Please note, if the member is receiving hemodialysis, contact the dialysis clinic for proper billing procedure.)

Current hemoglobin Date

☐ **Anemia due to cancer chemotherapy**

Current hemoglobin Date

☐ **Anemia due to myelosuppressive medication regimen for Hepatitis C**

Please provide antiviral medication regimen and dates of therapy.

Antiviral medication(s) Date

Current hemoglobin Date

For members using ribavirin, has ribavirin dose reduction been attempted without success?

☐ Yes. Please provide current ribavirin dose (after reduction).

☐ No. Please provide medical necessity for the use of requested agent.

Does the member have a history of cardiac disease? ☐ Yes ☐ No

☐ **Anemia due to myelosuppressive medication regimen for HIV**

Is member currently on zidovudine or zidovudine-containing products? ☐ Yes ☐ No

If yes, please provide current medication regimen.

Have other causes of anemia been ruled out (hemolysis, iron, vitamin B12, and folate deficiency)?
☐ Yes ☐ No. If no, please provide medical necessity for the use of requested agent.

Current hemoglobin Date

☐ **Decrease need for blood transfusions due to surgery**

Type of procedure Date of procedure

Please provide medical necessity for the use of requested agent.

Current hemoglobin Date

☐ **Other**

Please provide medical necessity for the use of erythropoietin (including diagnosis with etiology, current hemoglobin, other disease states, etc.).

Section II. Please also complete for recertification requests.

1. Is the member's hemoglobin currently > 12 g/dL?
   ☐ Yes. Please answer both questions below.
   Please provide the treatment plan to hold or reduce the erythropoietin dose.

   Date last erythropoietin dose was administered
   ☐ No
2. For members with anemia due to chemotherapy or myelosuppressive medication, please provide the most recent date of use for the causative agent.

   Medication(s) Date

Section III. Please complete for Procrit and Retacrit requests.

Please provide clinical rationale for use of the requested agent instead of Epogen.

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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

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

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.)