



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
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<input type="checkbox"/> 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)

<input type="checkbox"/> Fallon Health Online Prior Authorization: go.covermyeds.com/OptumRx Online Prior Authorization: providerportal.surescripts.net/ProviderPortal/optum Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033
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<input type="checkbox"/> Health New England Online Prior Authorization: go.covermyeds.com/OptumRx Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545

<input type="checkbox"/> Mass General Brigham Health Plan Online Prior Authorization (Non-Specialty Drugs): go.covermyeds.com/OptumRx Online Prior Authorization (Specialty/Medical Drugs): provider.massgeneralbrighamhealthplan.org Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555

<input type="checkbox"/> Tufts Health Plan Online Prior Authorization: point32health.promptpa.com Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985
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<input type="checkbox"/> 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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Gonadotropin-Releasing Hormone 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

- | | |
|--|---|
| <input type="checkbox"/> Camcevi (leuprolide) | <input type="checkbox"/> Oriahnn (elagolix/estradiol/norethindrone) |
| <input type="checkbox"/> Eligard (leuprolide) | <input type="checkbox"/> Orilissa (elagolix) |
| <input type="checkbox"/> Fensolvi (leuprolide) | <input type="checkbox"/> Supprelin LA (histrelin) |
| <input type="checkbox"/> Firmagon (degarelix) | <input type="checkbox"/> Synarel (nafarelin) |
| <input type="checkbox"/> Lupaneta Pack (leuprolide/norethindrone) | <input type="checkbox"/> Trelstar (triptorelin) ^{MB} |
| <input type="checkbox"/> Lupron (leuprolide) | <input type="checkbox"/> Triptodur (triptorelin) |
| <input type="checkbox"/> Myfembree (relugolix/estradiol/norethindrone) | <input type="checkbox"/> Vantas (histrelin) |
| <input type="checkbox"/> Orgovyx (relugolix) | |

^{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.

Dose, frequency, and duration of medication requested

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

- | | |
|---|--|
| <input type="checkbox"/> Advanced breast cancer | <input type="checkbox"/> Idiopathic or neurogenic central precocious puberty (CPP) |
| <input type="checkbox"/> Advanced prostate cancer | <input type="checkbox"/> Uterine leiomyomata (fibroids) |
| <input type="checkbox"/> Endometrial thinning prior to ablation for abnormal uterine bleeding | <input type="checkbox"/> Other <input type="text"/> |
| <input type="checkbox"/> Endometriosis | |

Please indicate billing preference. Pharmacy Prescriber in-office Hospital outpatient

If applicable, please also complete section for professionally administered medications at end of form.

Section I. Please complete for requests for idiopathic or neurogenic CPP.

1. Provide age of secondary sex characteristics onset.
2. Is the member under the care of a pediatric endocrinologist?
 Yes. Name of member's pediatric endocrinologist Date of last visit
 No. Please attach medical records of a consultation with a pediatric endocrinologist.

3. For Fensolvi and Triptodur, has the member tried Lupron and experienced an adverse reaction or inadequate response?

Yes. Please provide date and outcome for trial.

Date(s) Outcome(s)

No. Please explain.

Section II. Please complete for requests for endometriosis.

1. Has the member tried non-steroidal anti-inflammatory drugs (NSAIDs) and experienced an adverse reaction or inadequate response?

Yes. Provide drug names, dates, and outcomes for trials below.

Drug name(s) Date(s) Outcome(s)

No. Please explain if there is a contraindication to this trial.

2. Has the member tried hormonal contraceptives and experienced an adverse reaction or inadequate response?

Yes. Provide drug names, dates, and outcomes for trials below.

Drug name(s) Date(s) Outcome(s)

No. Please explain if there is a contraindication to this trial.

3. For Myfembree and Orilissa, has the member tried Lupron and experienced an adverse reaction or inadequate response?

Yes. Please provide date and outcome for trial.

Date(s) Outcome(s)

No. Please explain if there is a contraindication to this trial.

Section III. Please complete for requests for endometrial thinning prior to ablation for abnormal uterine bleeding and uterine leiomyomata (fibroids).

1. Is surgery planned?

Yes. Please provide anticipated date of surgery.

No. Please explain.

2. Has the member tried hormonal contraceptives and experienced an adverse reaction or inadequate response?

Yes. Please provide date and outcome for trial.

Date(s) Outcome(s)

No. Please explain.

3. For Myfembree and Oriahhn, has the member tried Lupron and experienced an adverse reaction or inadequate response?

Yes. Please provide date and outcome for trial.

Date(s) Outcome(s)

No. Please explain.

4. For Myfembree, has the member tried Oriahhn and experienced an adverse reaction or inadequate response?

Yes. Please provide date and outcome for trial.

Date(s) Outcome(s)

No. Please explain.

Section IV. Please complete for requests for advanced prostate cancer.

1. Please indicate prescriber specialty. Oncology Urology Other

2. For Lupron, has the member tried Camcevi, Eligard, Supprelin LA, or Trelstar and experienced an adverse reaction or inadequate response?

Yes. Provide drug names, dates, and outcomes for trials below.

Drug name(s) Date(s) Outcome(s)

No. Please explain.

3. For Orgovyx, has the member tried Lupron Depot, Supprelin LA, or Trelstar and experienced an adverse reaction or inadequate response?

Yes. Provide drug names, dates, and outcomes for trials below.

Drug name(s) Date(s) Outcome(s)

No. Please explain.

4. For Orgovyx, has the member tried Firmagon and experienced an adverse reaction or inadequate response?

Yes. Please provide date and outcome for trial.

Date(s) Outcome(s)

No. Please explain.

Section V. Please complete for all other diagnoses, excluding advanced breast cancer.

Please describe the medical necessity for the use of gonadotropin-releasing hormone, including previous trials and outcomes.

Section VI. 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*	<input type="text"/>	First name*	<input type="text"/>	MI	<input type="text"/>
NPI*	<input type="text"/>	Individual MH Provider ID	<input type="text"/>		
DEA No.	<input type="text"/>	Office Contact Name	<input type="text"/>		
Address	<input type="text"/>	City	<input type="text"/>	State	<input type="text"/>
		Zip	<input type="text"/>		
Email address	<input type="text"/>				
Telephone No.*	<input type="text"/>	Fax No.*	<input type="text"/>		

* Required

Please also complete for professionally administered medications, if applicable.

Start date	<input type="text"/>	End date	<input type="text"/>		
Servicing prescriber/facility name	<input type="text"/>	<input type="checkbox"/>	Same as prescribing provider		
Servicing provider/facility address	<input type="text"/>				
Servicing provider NPI/tax ID No.	<input type="text"/>				
Name of billing provider	<input type="text"/>				
Billing provider NPI No.	<input type="text"/>				
Is this a request for recertification?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
CPT code	<input type="text"/>	No. of visits	<input type="text"/>	J code	<input type="text"/>
		No. of units	<input type="text"/>		

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.)