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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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Gout 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

- ☐ allopurinol 200 mg tablet
- ☐ colchicine capsule
- ☐ febuxostat
- ☐ Gloperba (colchicine solution)
- ☐ Krystexxa (pegloticase) [MB]

[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 and frequency of medication requested

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

- ☐ Prophylaxis of gout
- ☐ Treatment of gout
- ☐ Other
  (Attach a letter regarding medical necessity.)

Please provide any serum urate level results and date obtained.

1. Lab value Date obtained
2. Lab value Date obtained
3. Lab value Date obtained
4. Lab value Date obtained

Please provide creatinine clearance level result and date obtained. Date obtained

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 prophylactic use of colchicine capsule or Gloperba (colchicine solution) for gout with urate lowering therapy.*

1. Will the member be taking the requested medication concurrently with a new start of allopurinol, febuxostat, or probenecid?
   - ☐ Yes. Please document drug name with dose and frequency and dates of use.
     Drug Dose and Frequency Dates/Duration
   - ☐ No. Please describe clinical rationale why concurrent therapy is not appropriate for this member.

2. What is the expected duration of therapy? **Please note:** requests for > six months will require additional clinical rationale for need of further treatment.

3. Does the member have tophaceous gout? ☐ Yes ☐ No
4. For Gloperba, is there a medical necessity for the use of a solution formulation?

   ☐ Yes. Please explain.
   ☐ No
5. For colchicine capsule, please provide clinical rationale for the use instead of colchicine tablet.

Section II. Please complete for prophylactic use of colchicine capsule or Gloperba (colchicine solution) for gout without urate lowering therapy.*

1. Has the member tried allopurinol and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please document dose and frequency, dates of use, and outcome.

   Dose and Frequency Dates/Duration Outcome
   ☐ No. Please document if there is a contraindication to allopurinol therapy.
2. Has the member tried febuxostat and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please document dose and frequency, dates of use, and outcome.

   Dose and Frequency Dates/Duration Outcome

   ☐ No. Please document if there is a contraindication to febuxostat therapy.
3. For Gloperba, is there a medical necessity for the use of a solution formulation?

   ☐ Yes. Please explain.
   ☐ No
4. For colchicine capsule, please provide clinical rationale for the use instead of colchicine tablet.

Section III. Please complete for treatment of gout with Krystexxa (pegloticase).*

1. Has the member tried allopurinol and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please document dose and frequency, dates of use, and outcome.

   Dose and Frequency Dates/Duration Outcome
   ☐ No. Please document if there is a contraindication to allopurinol therapy.
2. Has the member tried febuxostat and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please document dose and frequency, dates of use, and outcome.

   Dose and Frequency Dates/Duration Outcome
   ☐ No. Please document if there is a contraindication to febuxostat therapy.

over

3. Has the member tried a uricosuric agent in combination with allopurinol or febuxostat and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please document drug names with dose and frequency, dates of use, and outcome.
   Drug Dose and Frequency
   Dates/Duration Outcome
   Drug Dose and Frequency
   Dates/Duration Outcome
   ☐ No. Please document if there is a contraindication to uricosuric agent therapy.

Section IV. Please complete for treatment of gout with febuxostat.*

1. Has the member tried allopurinol and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please document dose and frequency, dates of use, and outcome.
   Dose and Frequency Dates/Duration Outcome
   ☐ No. Please document if there is a contraindication to allopurinol therapy.
2. For requests exceeding quantity limits, please provide medical necessity for dosing.

Section V. Please complete for treatment of gout with allopurinol 200 mg tablet.*

1. Please attach medical records documenting an inadequate response or adverse reaction to allopurinol two-100 mg tablets.
2. Please describe the medical necessity for use of allopurinol 200 mg tablet instead of two 100 mg tablets.

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

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.

over

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.

over

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.)