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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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Headache Therapy (Ergot Alkaloids and Serotonin Receptor 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

Ergot Alkaloids

- ☐ dihydroergotamine injection
- ☐ dihydroergotamine nasal spray
- ☐ ergotamine/caffeine suppository
- ☐ ergotamine/caffeine tablet
- ☐ Trudhesa (dihydroergotamine nasal spray)

Serotonin Receptor Agents

- ☐ almotriptan
- ☐ eletriptan
- ☐ frovatriptan
- ☐ naratriptan > quantity limits
- ☐ Reyvow (lasmiditan)
- ☐ rizatriptan orally disintegrating tablet > quantity limits
- ☐ rizatriptan tablet > quantity limits
- ☐ sumatriptan injection
- ☐ sumatriptan 5 mg, 20 mg nasal spray > quantity limits
- ☐ sumatriptan tablet > quantity limits
- ☐ sumatriptan/naproxen
- ☐ Tosymra (sumatriptan 10 mg nasal spray)
- ☐ Zembrace (sumatriptan injection)
- ☐ zolmitriptan nasal spray
- ☐ zolmitriptan orally disintegrating tablet
- ☐ zolmitriptan tablet > quantity limits

☐ Other* _____

**If request is for a non-preferred brand name or generic product, please attach supporting documentation (e.g., copies of medical records and/or office notes regarding adverse reaction or inadequate response to the preferred product).*

Quantity requested per 30 days _____

Dose, frequency, and duration of requested drug _____

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

☐ Cluster headache. Frequency of headaches (number/30 days) _____

☐ Migraine headache. Frequency of migraine attacks (number/30 days) _____

☐ Other. Specify pertinent medical history, diagnostic studies, and/or laboratory tests. _____

_____

Section I. Please complete for all serotonin receptor agent requests, excluding generic naratriptan, rizatriptan orally disintegrating tablet, rizatriptan tablets, sumatriptan 5 mg, 20 mg nasal spray, sumatriptan tablets, and zolmitriptan tablets. Please note, this section must be completed for brand name Imitrex tablet, Maxalt MLT, Maxalt tablet, or Zomig tablet requests.

1. Has the member tried sumatriptan tablets?
   ☐ Yes. Please describe the outcome. ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.

   ☐ No. Explain why sumatriptan tablets are not appropriate for this member.
2. Has the member tried rizatriptan?
   ☐ Yes. Please describe the outcome. ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.

   ☐ No. Explain why rizatriptan is not appropriate for this member.
3. Has the member tried zolmitriptan tablets?
   ☐ Yes. Please describe the outcome. ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.

   ☐ No. Explain why zolmitriptan tablets are not appropriate for this member.

Section II. Please complete for all requests for quantities above quantity limits.

1. Is the member under the care of a neurologist? ☐ Yes ☐ No
2. Is the member currently receiving prophylaxis?
   ☐ Yes. Please specify.
   Drug Dose and frequency
   Drug Dose and frequency
   ☐ No. Explain why prophylaxis is not appropriate for this member.

Section III. Please complete for requests for sumatriptan injection, Tosymra, Zembrace, zolmitriptan nasal spray and zolmitriptan orally disintegrating tablets.

1. Please describe medical necessity for the use of the requested dosage formulation instead of tablet formulation.
2. For Tosymra requests, has the member had a trial with zolmitriptan or sumatriptan 5 mg, 20 mg nasal spray?
   ☐ Yes. Please describe the outcome. ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.

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☐ No. Explain why zolmitriptan or sumatriptan 5 mg, 20 mg nasal spray is not appropriate for this member.

3. For Zembrace requests, has the member had a trial with sumatriptan injection?
   ☐ Yes. Please describe the outcome. ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.

   ☐ No. Explain why sumatriptan injection is not appropriate for this member.

Section IV. Please complete for requests for sumatriptan/naproxen.

Please describe medical necessity for the use of the combination product (sumatriptan/naproxen) instead of the commercially-available separate agents.

Section V. Please complete for requests for Reyvow.

1. Is the member under the care of a neurologist? ☐ Yes ☐ No
2. Has the member had a trial with two different triptan agents?
   ☐ Yes. Please describe the drug names and outcomes.

   Drug name ☐ Adverse reaction ☐ Inadequate response
   Briefly describe the details of adverse reaction or inadequate response.

   Drug name ☐ Adverse reaction ☐ Inadequate response
   Briefly describe the details of adverse reaction or inadequate response.

   ☐ No. Explain why triptan agents are not appropriate for this member.

Section VI. Please complete for dihydroergotamine nasal spray and Trudhesa requests.

1. Has the member tried sumatriptan nasal spray?
   ☐ Yes. Please describe the outcome. ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.

   ☐ No. Explain why sumatriptan nasal spray is not appropriate in this member.

2. Has the member tried zolmitriptan nasal spray?
   ☐ Yes. Please describe the outcome. ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.

   ☐ No. Explain why zolmitriptan nasal spray is not appropriate in this member.

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Section VII. Please complete for ergotamine/caffeine tablet requests.

1. Has the member tried sumatriptan tablets?
   ☐ Yes. Please describe the outcome. ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.

   ☐ No. Explain why sumatriptan tablets are not appropriate in this member.

2. Has the member tried rizatriptan?
   ☐ Yes. Please describe the outcome. ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.

   ☐ No. Explain why rizatriptan is not appropriate in this member.

Section VIII. Please complete for dihydroergotamine injection and ergotamine/caffeine suppository requests.

1. Please describe medical necessity for the use of the requested dosage formulation.

2. For dihydroergotamine injection requests, has the member tried sumatriptan injection?
   ☐ Yes. Please describe the outcome. ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.

   ☐ No. Explain why sumatriptan injection is not appropriate in this member.

3. For ergotamine/caffeine suppository requests, has the member tried sumatriptan nasal spray?
   ☐ Yes. Please describe the outcome. ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.

   ☐ No. Explain why sumatriptan nasal spray is not appropriate in this member.

Section IX. 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.)