



# 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.covermyeds.com/OptumRx](http://go.covermyeds.com/OptumRx)  
Online Prior Authorization: [providerportal.surescripts.net/ProviderPortal/optum](http://providerportal.surescripts.net/ProviderPortal/optum)  
Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033

**Health New England**  
Online Prior Authorization: [go.covermyeds.com/OptumRx](http://go.covermyeds.com/OptumRx)  
Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545

**Mass General Brigham Health Plan**  
Online Prior Authorization (Non-Specialty Drugs): [go.covermyeds.com/OptumRx](http://go.covermyeds.com/OptumRx)  
Online Prior Authorization (Specialty/Medical Drugs): [provider.massgeneralbrighamhealthplan.org](http://provider.massgeneralbrighamhealthplan.org)  
Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555

**Tufts Health Plan**  
Online Prior Authorization: [point32health.promptpa.com](http://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](http://wellsense.org/providers/ma/pharmacy/prior-authorizations)  
Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822

# Hemophilia Gene Therapies 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](http://www.mass.gov/druglist).

## Medication information

### Medication requested

- Hemgenix (etranacogene dezparvovec-drlb)<sup>MB</sup>  
 Roctavian (valoctocogene roxaparvovec-rvox)<sup>MB</sup>

### Dose and frequency of medication requested

### Indication or ICD-10 code, if applicable

- Severe hemophilia A  
 Moderately severe to severe hemophilia B

<sup>MB</sup> 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.

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

- Is the prescriber a hematologist?  Yes  
 No. Please attach consultation notes from a hematologist.

## Section I. Please complete for all requests.

1. Please provide anticipated dates and dosing for the following as applicable.

Admission  Infusion  Dose  Discharge

2. Will the member be screened for acute infection prior to administration?  Yes  No

3. Baseline weight  Date

4. Baseline annualized bleeding rate (ABR)  Date

## Section II. Please also complete for requests for Hemgenix.

1. Is the member currently receiving immunosuppressive therapy?  Yes  No  
2. Does the member currently have a life-threatening hemorrhage?  Yes  No  
3. Does the member have a history of life-threatening hemorrhage?  Yes  No  
4. Has the member had repeated, serious spontaneous bleeding episodes?  Yes  No  
5. Does the member currently use FIX prophylaxis therapy?

Yes. Please provide details.   No

6. FIX activity level  Date  over

7. NAb titer (AAV5)  Date

**Section III. Please also complete for requests for Roctavian.**

1. Has the member been assessed for their ability to receive corticosteroids and/or immunosuppressive therapy?  Yes  No
2. Does the member currently use FVIII prophylaxis therapy?  
 Yes. Please provide details.   
 No. If no, does the member currently use Hemlibra (emicizumab)?  Yes  No
3. FVIII activity level  Date
4. Does the member have a detectable pre-existing immunity to AAV5?  Yes  No
5. Does the member have a history of factor VIII inhibitor?  Yes  No
6. Does the member have hepatic fibrosis?  Yes  No
7. Does the member have cirrhosis?  Yes  No
8. Does the member have history of thrombosis or thrombophilia?  Yes  No
9. Does the member have an active malignancy?  Yes  No

**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

# 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.)