Print Clear

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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Hepatitis Antiviral 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**.

Diagnosis

☐ Hepatitis C

☐ Acute ☐ Chronic

☐ HIV-coinfection ☐ Renal impairment. Creatinine clearance _____ ☐ Status post-liver transplant

HCV Genotype ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Other _____

☐ Treatment-experienced (Please complete the section for Prior Hepatitis Treatment.) ☐ Treatment-naïve

☐ Treatment initiation Anticipated start date _____ Anticipated end date _____

☐ Continuation of therapy, current week _____

☐ Chronic Hepatitis B

Fibrosis Staging

Please indicate below and attach documentation including medical records and results of diagnostic tests assessing liver disease staging (e.g., APRI, Fibroscan, Fibrosure, FIB-4). Staging information must clearly demonstrate early stage (Metavir Score F0 to F2) or advance liver disease (Metavir Score F3 to F4). If results are inconclusive or if imaging studies are performed and are not suggestive of cirrhosis, further diagnostic testing may be required.

☐ Metavir Score F0 to F2 ☐ Metavir Score F3 to F4 ☐ Other _____

Does the member have cirrhosis? ☐ Yes ☐ No

If yes, please indicate Child-Turcotte-Pugh (CTP) class. (Please attach calculations.) ☐ A ☐ B ☐ C

Drug Interactions

Does the member currently take prescription or over-the-counter medications that may interact with the requested regimen (e.g., proton pump inhibitors, H2-receptor antagonists, anticonvulsants, HIV antiretrovirals, HMG CoA reductase inhibitors, antimycobacterials, St. John's Wort)?

☐ Yes ☐ No

Please attach medication list and describe the plan to manage the interaction(s).

_____

Lab Values

Baseline HCV RNA lab value _____ Date drawn _____

Prior Hepatitis Treatment

Drug name _____ Dates/duration of use _____

Please indicate treatment outcome. ☐ Adverse reaction ☐ Null responder ☐ Partial responder ☐ Relapser ☐ Other

Briefly describe details. _____

Drug name _____ Dates/duration of use _____

Please indicate treatment outcome. ☐ Adverse reaction ☐ Null responder ☐ Partial responder ☐ Relapser ☐ Other

Briefly describe details. _____

Drug name _____ Dates/duration of use _____

Please indicate treatment outcome. ☐ Adverse reaction ☐ Null responder ☐ Partial responder ☐ Relapser ☐ Other

Briefly describe details. _____

Complete Treatment Regimen (Check All that Apply)

HCV Combination Agents

☐ ledipasvir/sofosbuvir
☐ Mavyret (glecaprevir/pibrentasvir)
☐ sofosbuvir/velpatasvir
☐ Viekira Pak (ombitasvir/paritaprevir/ritonavir/ dasabuvir)
☐ Vosevi (sofosbuvir/velpatasvir/voxilaprevir)
☐ Zepatier (elbasvir/grazoprevir)

Dose/frequency _____ Duration of therapy _____

For sofosbuvir/velpatasvir requests only, for members with HCV genotype 3 who are treatment-experienced without cirrhosis, please indicate if NS5A resistance-associated substitution Y93H is present. (Please attach laboratory testing results.) ☐ Yes ☐ No

For Zepatier requests only, for members with HCV genotype 1a, please indicate if baseline NS5A polymorphisms at amino acid positions 28, 30, 31 or 93 are present. (Please attach laboratory testing results.) ☐ Yes ☐ No

HCV Single Agents

☐ Sovaldi (sofosbuvir)

Dose/frequency _____ Duration of therapy _____

Pegylated Interferon

☐ Pegasys (peginterferon alfa-2a) ☐ Pegintron (peginterferon alfa-2b)

Dose/frequency _____ Duration of therapy _____

Ribavirin

☐ ribavirin 200 mg capsule
☐ None. Please explain the clinical rationale for not using ribavirin below.

Dose/frequency _____ Duration of therapy _____

Please indicate if using ribavirin 200 mg tablets. ☐ Yes ☐ No

Please describe medical necessity for use of the other products instead of the 200 mg tablet.

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If applicable, please explain the clinical rationale for not using ribavirin.

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.

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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.)