



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
Online Prior Authorization: providerportal.surescripts.net/ProviderPortal/optum
Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033

Health New England
Online Prior Authorization: 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
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

Hyaluronan Injections

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.

Device information

Device requested

- | | |
|---|---|
| <input type="checkbox"/> Durolane (hyaluronate) ^{MB} | <input type="checkbox"/> Orthovisc (high molecular weight hyaluronan) ^{MB} |
| <input type="checkbox"/> Euflexxa (hyaluronate) ^{MB} | <input type="checkbox"/> Supartz (hyaluronate) ^{MB} |
| <input type="checkbox"/> Gel-One (cross-linked hyaluronate) ^{MB} | <input type="checkbox"/> Synjoynt (hyaluronate) ^{MB} |
| <input type="checkbox"/> Gelsyn (hyaluronate) ^{MB} | <input type="checkbox"/> Synvisc (hylan G-F 20) ^{MB} |
| <input type="checkbox"/> Genvisc (hyaluronate) ^{MB} | <input type="checkbox"/> Synvisc-One (hylan G-F 20) ^{MB} |
| <input type="checkbox"/> Hyalgan (hyaluronate) ^{MB} | <input type="checkbox"/> Triluron (hyaluronate) ^{MB} |
| <input type="checkbox"/> Hymovis (hyaluronate modified) ^{MB} | <input type="checkbox"/> Trivisc (hyaluronate) ^{MB} |
| <input type="checkbox"/> Monovisc (hyaluronate) ^{MB} | <input type="checkbox"/> Visco-3 (hyaluronate) ^{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, frequency and duration of device requested

Device NDC (if known) or service code

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

Osteoarthritis of the knee Left knee Right knee Both knees

Other (Please indicate.)

Is the request for retreatment of the same knee(s)? Yes No

Section I. Please complete the following for all requests.

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

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

2. Has the member tried acetaminophen?

Yes. Please provide the following information.* 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.

No. Does the member have a contraindication to acetaminophen? Please explain.

3. Has the member tried an intra-articular corticosteroid injection?

Yes. Please provide the following information.*

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.

No. Does the member have a contraindication to all intra-articular corticosteroid injections? Please explain.

4. Has the member tried a non-steroidal anti-inflammatory drug (NSAID)?

Yes. Please provide the following information.*

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.

No. Does the member have a contraindication to all NSAIDs? Please explain.

* Please attach a letter documenting additional trials as necessary.

Section II. 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.)