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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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Inhaled Respiratory 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 (Check one or all that apply. Where applicable, the brand name is provided in brackets for reference.)

Anticholinergics

- ☐ Lonhala (glycopyrrolate)
- ☐ Yupelri (revefenacin)

Combination Products

- ☐ Airduo Digihaler (fluticasone/salmeterol)
- ☐ Airsupra (albuterol/budesonide)
- ☐ Bevespi (glycopyrrolate/formoterol)
- ☐ Breztri (budesonide/glycopyrrolate/formoterol)
- ☐ Duaklir (aclidinium/formoterol)
- ☐ fluticasone/salmeterol [Airduo Respiclick]
- ☐ Stiolto (tiotropium/olodaterol)
- ☐ Trelegy (fluticasone furoate/umeclidinium/ vilanterol)

Corticosteroids

- ☐ Alvesco (ciclesonide inhaler)
- ☐ Armonair Digihaler (fluticasone propionate)
- ☐ Asmanex (mometasone) 110 mcg ≥ 12 years
- ☐ Asmanex (mometasone) 220 mcg < 12 years
- ☐ budesonide inhalation suspension ≥ 13 years
- ☐ fluticasone propionate inhalation aerosol ≥ 5 years [Flovent] ±
- ☐ fluticasone propionate inhalation powder [Flovent] ±
- ☐ Qvar Redihaler (beclomethasone inhaler)

Long-acting Beta Agonists

- ☐ arformoterol
- ☐ formoterol
- ☐ Striverdi (olodaterol)

Short-acting Beta Agonists

- ☐ albuterol inhaler ‡
- ☐ levalbuterol inhalation solution
- ☐ Proair Digihaler (albuterol inhalation powder)

‡Brand name Proair, Proventil, and Ventolin are available without prior authorization.
±Brand name Flovent is available without prior authorization.

Other Medication

☐ 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).*

Dose and frequency of medication requested _____

Number of inhalers/month _____

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

☐ Asthma (Specify severity below.)

☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

☐ Chronic Obstructive Pulmonary Disease (COPD) (Specify severity and subtype below.)

Severity ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

Subtype ☐ Chronic bronchitis ☐ Emphysema

☐ Exercise-induced bronchospasm

☐ Reactive airway disease

☐ Other

Please list all other medications currently prescribed for the member for this indication.

Is this member a referral candidate for care coordination? ☐ Yes ☐ No
If yes, MassHealth will offer care coordination services to this member. Please describe which additional behavioral health services would be beneficial.

Section I. Please complete for albuterol inhaler and Proair Digihaler requests.

1. For requests for albuterol inhaler, please attach medical records documenting an inadequate response or adverse reaction to an albuterol product available without prior authorization. *
2. For requests for Proair Digihaler, has the member had a trial with brand name Proair, Proair Respiclick, Proventil, or Ventolin?
   ☐ Yes. Please list the dates/duration of trials, and outcomes in Section X.
   ☐ No. Please describe the clinical rationale why an albuterol inhaler is not appropriate for this member.

** Brand name Proair, Proventil, and Ventolin do not require prior authorization*.

Section II. Please complete for Asmanex 110 mcg requests in members ≥ 12 years of age and 220 mcg in members < 12 years of age.

Please describe the clinical rationale for the use of requested Asmanex strength in the requested age group.

Section III. Please complete for all arformoterol, budesonide inhalation suspension, formoterol, levalbuterol inhalation solution, Lonhala, and Yupelri requests.

1. Please describe the medical necessity for a nebulized formulation.
2. For levalbuterol inhalation solution, has the member had a trial with albuterol solution?
   ☐ Yes. Please list the dates/duration of trials, and outcomes in Section X.
   ☐ No. Please describe the clinical rationale why albuterol solution is not appropriate for this member.
3. For Lonhala and Yupelri, has the member had a trial with ipratropium inhalation nebulizer solution?
   ☐ Yes. Please list the dates/duration of trials, and outcomes in Section X.
   ☐ No. Please describe the clinical rationale why ipratropium inhalation nebulizer solution is not appropriate for this member.

Section IV. Please complete for Airduo Digihaler, and fluticasone/salmeterol (generic Airduo Respiclick) requests.

1. Has the member had a trial with fluticasone/salmeterol inhalation aerosol, powder (generic Advair)?
   ☐ Yes. Please list the dates/duration of trials and the outcomes in Section X.
   ☐ No. Please describe the clinical rationale for use of the requested agent in this member.

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2. For Airduo Digihaler, has the member had a trial with fluticasone/salmeterol (generic Airduo Respiclick)?
   ☐ Yes. Please list the dates/duration of trials, and outcomes in Section X.
   ☐ No. Please describe the clinical rationale for use of the requested agent in this member.

Section V. Please complete for Alvesco, Armonair Digihaler, fluticasone propionate inhalation aerosol and powder (generic Flovent)‡, and Qvar Redihaler requests.

Has the member had a trial with two inhaled corticosteroids?
☐ Yes. Please list the dates/duration of trials, and outcomes in Section X.
☐ No. Please document if there is a contraindication to all other inhaled corticosteroids.

‡ *Brand name Flovent does not require prior authorization*.

Section VI. Please complete for Bevespi and Duaklir requests.

Has the member had a trial with Anoro or Stiolto?
☐ Yes. Please list the dates/duration of trials, and outcomes in Section X.
☐ No. Please describe the clinical rationale for use of the requested agent in this member.

Section VII. Please complete for Trelegy requests.

Has the member had a trial with fluticasone/vilanterol and Incruse or Anoro and Arnuity?
☐ Yes. Please list the dates/duration of trials, and outcomes in Section X.
☐ No. Please describe the clinical rationale for use of the requested agent in this member.

Section VIII. Please complete for Breztri requests.

Has the member had a trial with the following combination of the separate agents: Bevespi and Pulmicort inhalation powder?
☐ Yes. Please list the dates/duration of trials, and outcomes in Section X.
☐ No. Please describe the clinical rationale for use of the requested agent in this member.

Section IX. Please complete for Airsupra requests.

Has the member had a trial with budesonide/formoterol or albuterol and Pulmicort inhalation powder?
☐ Yes. Please list the dates/duration of trials, and outcomes in Section X.
☐ No. Please describe the clinical rationale for use of the requested agent in this member.

Section X. Please complete as instructed in sections above.*

Drug name Dates/duration of use
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
Briefly describe details of adverse reaction, inadequate response, or other.

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Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

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

Section XI. 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.)