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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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Lipid-Lowering 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

Statins

- ☐ Altoprev (lovastatin extended-release)
- ☐ Atorvaliq (atorvastatin suspension)
- ☐ atorvastatin > quantity limits
- ☐ atorvastatin/amlodipine
- ☐ Ezallor (rosuvastatin sprinkle capsule)
- ☐ fluvastatin
- ☐ fluvastatin extended-release
- ☐ Leqvio (inclisiran)
- ☐ lovastatin > quantity limits
- ☐ pitavastatin calcium
- ☐ pravastatin > quantity limits
- ☐ rosuvastatin > quantity limits
- ☐ simvastatin > quantity limits
- ☐ simvastatin/ezetimibe > quantity limits
- ☐ Zypitamag (pitavastatin magnesium)

Fibric Acids

- ☐ fenofibrate tablet 40 mg, 120 mg

Miscellaneous Agents

- ☐ Evkeeza (evinacumab-dgnb) [MB]
- ☐ icosapent ethyl
- ☐ Juxtapid (lomitapide)
- ☐ Nexletol (bempedoic acid)
- ☐ Nexlizet (bempedoic acid/ezetimibe)

PCSK9 Inhibitors

- ☐ Praluent (alirocumab)
- ☐ Repatha (evolocumab)

Other Lipid-Lowering Agents

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).*

[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 requested medication _____ **Quantity requested per month** _____

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

- ☐ Atherosclerotic cardiovascular (CV) disease
- ☐ CV risk reduction
- ☐ Heterozygous familial hypercholesterolemia
- ☐ Homozygous familial hypercholesterolemia
- ☐ Hypercholesterolemia
- ☐ Hypercholesterolemia with previous history of any cardiovascular event
- ☐ Hypertriglyceridemia
- ☐ Mixed dyslipidemia
- ☐ Primary hyperlipidemia
- ☐ Other. Specify pertinent medical history, diagnostic studies, and/or laboratory results.

Please indicate billing preference. ☐ Pharmacy ☐ Prescriber in-office ☐ Hospital outpatient
If applicable, please also complete section for professionally administered medications at end of form.

Drug NDC (if known) or service code

Please indicate prescriber specialty.

☐ Cardiology ☐ Other

☐ Specialist consult details (if the prescriber submitting the request is not a specialist)

Name(s) of the specialist(s)

Date(s) of last visit or consult

Contact Information

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.

Lab Values and Treatment Plan: Please complete for all requests.

1. Is this a request for treatment initiation?
   ☐ Yes. Please provide the current baseline laboratory values.
   Date
   Total cholesterol mg/dl LDL/LDL-C mg/dl
   HDL mg/dl Triglycerides mg/dl
   ☐ No
2. Is this a request for continuation of treatment?
   ☐ Yes. Please provide the current laboratory values following treatment demonstrating efficacy of the requested agent.
   Date
   Total cholesterol mg/dl LDL/LDL-C mg/dl
   HDL mg/dl Triglycerides mg/dl
   ☐ No
3. Please summarize treatment goals including target cholesterol levels.

Please note: High-intensity statin therapy is defined as atorvastatin 40 mg, 80 mg, and rosuvastatin 20 mg, 40 mg.

Section I. Please complete if this request is for Altoprev, fluvastatin, fluvastatin extended-release, pitavastatin calcium, or Zypitamag.

1. Has the member had an inadequate response to a high-intensity statin for at least three months?
   ☐ Yes ☐ No
2. Has the member tried a high-intensity statin and had an adverse reaction or does the member have a contraindication to all high-intensity statins?
   ☐ Yes. Please explain.

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☐ No. Clinical rationale for not trying a high intensity statin.

Section II. Please complete if this request is for quantities above quantity limits.

Please attach documentation of the clinical rationale for the requested dose, quantity, and frequency, including a detailed treatment plan. Specify pertinent medical history, diagnostic studies, and/or lab results.

Section III. Please complete if this request is for fenofibrate tablet 40 mg or 120 mg.

Please attach medical records documenting failure with a therapeutically equivalent fenofibrate formulation available without prior authorization.

Section IV. Please complete if this request is for atorvastatin/amlodipine.

Please describe medical necessity for use of the combination product instead of the commercially available separate agents.

Section V. Please complete if this request is for icosapent ethyl for hypertriglyceridemia (not inclusive of those with established cardiovascular disease (CVD) or diabetes mellitus and CV risk factors).

1. Has the member had a trial with omega-3 acid ethyl esters?
   ☐ Yes. Please list the dose and frequency, dates/duration of trial, and outcome below.
   Dose and frequency 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.
   ☐ No. Please document if there is a contraindication to omega-3 acid ethyl esters.
2. Has the member had a trial with a fibric acid derivative?
   ☐ Yes. Please list the drug name, dose and frequency, dates/duration of trials, and outcomes below.
   Drug name Dose and frequency 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.
   ☐ No. Please document if there is a contraindication to all fibric acid derivatives.

Section VI. Please complete if this request is for icosapent ethyl for cardiovascular risk reduction.

1. Does the member have established cardiovascular disease (CVD)?
   ☐ Yes. Please describe.
   ☐ No

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2. Does the member have diabetes mellitus with at least one risk factor for CVD?

☐ Yes. Please describe. _____

☐ No

3. Will icosapent ethyl will be used in combination with a statin?

☐ Yes

☐ No. Clinical rationale why member cannot take a statin. _____

Section VII. Please complete if this request is for Leqvio, Nexletol, Nexlizet, Praluent, or Repatha.

For Nexletol, Nexlizet, Praluent and Repatha requests, please complete questions 1, 2 and 3. For Leqvio requests, please complete questions 1 through 7.

1. Has the member had an inadequate response to a high-intensity statin in combination with ezetimibe for at least the last three months?

☐ Yes.

☐ Name of statin _____

Dose and frequency _____ Dates of use _____ Outcome _____

☐ ezetimibe

Dose and frequency _____ Dates of use _____ Outcome _____

☐ No

2. Has the member tried a high-intensity statin and had an adverse reaction or does the member have a contraindication to all high-intensity statins?

☐ Yes. Please explain. _____ ☐ No

3. Has the member tried ezetimibe and had an adverse reaction or does the member have a contraindication to this agent?

☐ Yes. Please explain. _____ ☐ No

4. Has the member had an inadequate response to Praluent or Repatha for at least the last three months?

☐ Yes. Please note: Requests will be evaluated taking into account MassHealth pharmacy claims history or additional documentation addressing adherence to this agent.

Drug name _____

Dose and frequency _____ Dates of use _____ Outcome _____

☐ No

5. Has the member tried Praluent and had an adverse reaction or does the member have a contraindication to this agent?

☐ Yes. Please explain. _____ ☐ No

6. Has the member tried Repatha and had an adverse reaction or does the member have a contraindication to this agent?

☐ Yes. Please explain. _____ ☐ No

7. If this is a request for continuation of treatment, has the member been adherent to the lipid-lowering regimen?

☐ Yes. Please note: Continued approval of the requested agent will be contingent upon MassHealth pharmacy claims history or additional documentation addressing adherence to the entire lipid-lowering regimen.

☐ No

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Section VIII. Please complete if this request is for Atorvaliq and Ezallor.

1. Please provide medical necessity for use of the requested formulation.
2. For Atorvaliq, please provide clinical rationale for use instead of Ezallor.

Section IX. Please complete if this request is for Juxtapid.

1. Does the member have laboratory testing results confirming genetic mutation associated with homozygous familial hypercholesterolemia including low density lipoprotein receptor mutations, PCSK9 mutations, and familial defective apoB mutations? ☐ Yes. Please attach laboratory testing results. ☐ No
2. Please provide the following laboratory values:

   Baseline LDL/LDL-C mg/dl Date

   Current LDL/LDL-C mg/dl Date
3. Did the member have evidence of xanthoma before 10 years of age? ☐ Yes ☐ No
4. Does the member have evidence of heterozygous familial hypercholesterolemia in both parents? ☐ Yes ☐ No
5. Has the member had an inadequate response to a high-intensity statin for at least three months?

   ☐ Yes. Drug name Dose and frequency Dates/duration of use

   ☐ No
6. Has the member tried a high-intensity statin and had an adverse reaction or does the member have a contraindication to all high-intensity statins?

   ☐ Yes. Please explain.

   ☐ No
7. Has the member had a trial with an additional non-statin lipid-lowering agent?

   ☐ Yes. Please list the drug name, dose and frequency, dates/duration of trials, and outcomes below.

   Drug name Dose and frequency 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.

   ☐ No. Please document if there is a contraindication to all non-statin lipid-lowering agents.
8. Will the requested agent be used in combination with a high-intensity statin?

   ☐ Yes. Please list the drug name and dose and frequency below.

   Drug name Dose and frequency

   ☐ No. Please explain.

Section X. Please complete if this request is for Evkeeza.

1. Does the member have laboratory testing results confirming genetic mutation associated with homozygous familial hypercholesterolemia including low density lipoprotein receptor mutations, PCSK9 mutations, and familial defective apoB mutations? ☐ Yes. Please attach laboratory testing results. ☐ No

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2. Please provide the following laboratory values:

   Baseline LDL/LDL-C _____ mg/dl Date _____

   Current LDL/LDL-C _____ mg/dl Date _____

3. Did the member have evidence of xanthoma before 10 years of age? ☐ Yes ☐ No
4. Does the member have evidence of heterozygous familial hypercholesterolemia in both parents?
   ☐ Yes ☐ No
5. Please provide member's current weight _____ Date _____
6. Will the requested agent be used in combination with a high-intensity statin, ezetimibe, and a PCSK9 inhibitor?
   ☐ Yes. Please list the drug name(s) and dose and frequency below.

   Drug name _____ Dose and frequency _____

   Drug name _____ Dose and frequency _____

   Drug name _____ Dose and frequency _____

   ☐ No. Please explain. _____

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

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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.)