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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Multiple Myeloma 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

- ☐ Blenrep (belantamab mafodotin-blmf)
- ☐ Darzalex (daratumumab) [MB]
- ☐ Darzalex Faspro (daratumumab-hyaluronidase-fihj) [MB]
- ☐ Empliciti (elotuzumab) [MB]
- ☐ Kyprolis (carfilzomib) [MB]
- ☐ Ninlaro (ixazomib)
- ☐ Pomalyst (pomalidomide)
- ☐ Sarclisa (isatuximab-irfc) [MB]
- ☐ Xpovio (selinexor)

[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 medication requested ______

Height ______ Weight ______ Date ______

Please indicate prescriber specialty: ☐ Hematology ☐ Oncology ☐ Other ______

Will the requested agent be used as monotherapy for this indication? ☐ Yes ☐ No

If no, please list all other medications currently prescribed for the member that will be used concomitantly for this indication.

______

______

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 ______

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

☐ **Multiple myeloma**

Other Oncologic Indications

- ☐ Diffuse large B-cell lymphoma (DLBCL)
- ☐ Light chain amyloidosis
- ☐ Kaposi sarcoma
  - ☐ Acquired Immunodeficiency Syndrome (AIDS) and failed highly active antiretroviral therapy
  - ☐ Negative for Human Immunodeficiency Virus (HIV)

Please describe the stage and severity of disease.

Is the cancer metastatic? ☐ Yes ☐ No

Has the member had persistent or recurring disease following surgery and/or radiation therapy? ☐ Yes ☐ No

Is the member a candidate for surgery and/or radiation?

☐ Yes ☐ No. Please describe.

Section I. Please complete for all requests.

Please list any other prior trials. Please list the drug names, dates/duration of use and outcomes below.*

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.

Drug name Dates/duration of use

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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.

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

Section II. Please complete for Blenrep, and Xpovio for monotherapy requests.

1. Has the member received at least four prior chemotherapy regimens? ☐ Yes. Complete Section I. ☐ No
2. Is the member's disease refractory to at least one proteasome inhibitor (for Blenrep requests) or two proteasome inhibitors (for Xpovio requests), or does the member have a contraindication to proteasome inhibitors? ☐ Yes. Complete Section I. ☐ No
3. Is the member's disease refractory to at least one immunomodulatory agent (for Blenrep requests) or two immunomodulatory agents (for Xpovio requests), or does the member have a contraindication to immunomodulatory agents? ☐ Yes. Complete Section I. ☐ No
4. Is the member's disease refractory to at least one anti-CD38 monoclonal antibody, or does the member have a contraindication to anti-CD38 monoclonal antibodies? ☐ Yes. Complete Section I. ☐ No

Section III. Please complete for requests for agents with a preferred alternative.

Please describe clinical rationale for use of the requested agent instead of the preferred alternative.

Section IV. Please complete for requests for quantities above quantity limits.

Please describe the clinical rationale for exceeding the quantity limit, including a detailed treatment plan.

Section V. Please include any other pertinent information (if needed).

Section VI. 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.)