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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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Oral/Injectable Antifungal 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

- ☐ Brexafemme (ibrexafungerp)
- ☐ Cresemba (isavuconazonium)*
- ☐ Noxafil (posaconazole powder for oral suspension)
- ☐ Oravig (miconazole buccal tablet)
- ☐ posaconazole injection, suspension*
- ☐ Rezzayo (rezafungin)
- ☐ Tolsura (itraconazole 65 mg capsule)
- ☐ Vivjoa (oteseconazole)
- ☐ voriconazole suspension, 50 mg tablet
- ☐ Other** _____

*For posaconazole IV and Cresemba IV, Section VII is also required.
**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 _____

Indication (check all that apply or include ICD-10 code, if applicable)
***voriconazole requests only **Cresemba and posaconazole**

- ☐ *Aspergillus* endophthalmitis*
- ☐ *Aspergillus* keratitis*
- ☐ *Scedosporium* infection*
- ☐ *Aspergillus* infection
- ☐ *Fusarium* infection*
- ☐ *Zygomycosis* (mucormycosis)**

Please note: For posaconazole or voriconazole for the above indications, Sections I through VIII are not required.

For all indications checked below, please complete sections in parentheses

- ☐ Blastomycosis (Section V)
- ☐ Candidemia (Section II) †
- ☐ Disseminated candidiasis (Section II)
- ☐ Esophageal candidiasis (Section III)
- ☐ Histoplasmosis (Section V)
- ☐ Invasive candidiasis (Section X)
- ☐ Onychomycosis (Section V)
- ☐ Oropharyngeal candidiasis (Section IV)
- ☐ Prevention of *Aspergillus* and *Candida* infections (Section I)
- ☐ Vulvovaginal candidiasis (Section IX)
- ☐ Other _____

(Please attach a letter regarding medical necessity.)

† For Rezzayo, please complete Section X

Section I. Please complete for posaconazole and voriconazole for prevention of Aspergillus and Candida infections.

1. For posaconazole requests, is the member's age within the FDA-approved range for use (posaconazole suspension ≥ 13 years; posaconazole powder for oral suspension ≥ 2 years to < 18 years; posaconazole IV ≥ 2 years)?
   ☐ Yes ☐ No. Please provide clinical rationale for use in non-FDA approved age.

   For both posaconazole and voriconazole requests, does the member have one of the following?
   ☐ Hematologic malignancy with neutropenia ☐ Graft-versus-host disease
   ☐ Hematopoietic stem cell transplantation
   ☐ No. Please describe why the member requires antifungal prophylaxis.
2. For posaconazole IV, please provide clinical rationale for use of IV formulation instead of oral formulations.
3. For posaconazole powder for oral suspension, is the member's weight ≤ 40 kg?
   ☐ Yes ☐ No. Please provide clinical rationale for use in non-FDA approved weight.

Section II. Please complete for voriconazole for candidemia and disseminated candidiasis.

Has the member had a trial of oral fluconazole?

☐ Yes. Dates/durations of use
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response
Briefly describe details of adverse reaction or inadequate response.

☐ No. Please describe why the member is not a candidate for oral fluconazole.

Section III. Please complete for posaconazole suspension and voriconazole for esophageal candidiasis.

1. For posaconazole requests, is the member 13 years of age or older?
   ☐ Yes ☐ No. Please provide clinical rationale for use in non-FDA-approved age.
2. For posaconazole requests, has the member had a trial of voriconazole?
   ☐ Yes. 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. Please describe why the member is not a candidate for voriconazole.

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3. For both posaconazole and voriconazole requests, has the member had a trial of fluconazole?

☐ Yes. 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. Please describe why the member is not a candidate for fluconazole.

4. For both posaconazole and voriconazole requests, has the member had a trial of itraconazole?

☐ Yes. 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. Please describe why the member is not a candidate for itraconazole.

Section IV. Please complete for Oravig, posaconazole suspension, and voriconazole for oropharyngeal candidiasis.

1. For posaconazole requests, is the member 13 years of age or older?

☐ Yes ☐ No. Please provide clinical rationale for use in non-FDA approved age.

2. For voriconazole requests, has the member had a trial of posaconazole?

☐ Yes. 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. Please describe why the member is not a candidate for posaconazole.

3. For both posaconazole and voriconazole requests, has the member had a trial of oral fluconazole?

☐ Yes. 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. Please describe why the member is not a candidate for oral fluconazole.

4. For both posaconazole and voriconazole requests, has the member had a trial of itraconazole?

☐ Yes. 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. Please describe why the member is not a candidate for itraconazole.

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5. For Oravig requests, has the member had a trial of clotrimazole troches?

☐ Yes. 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. Please describe why the member is not a candidate for clotrimazole troches.

6. For Oravig requests, has the member had a trial of nystatin suspension?

☐ Yes. 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. Please describe why the member is not a candidate for nystatin suspension.

Section V. Please complete for Tolsura.

Please provide medical necessity for the requested formulation instead of itraconazole 100 mg capsules.

Section VI. Please complete for Cresemba for the treatment of Aspergillus infection.

1. Has the member had a trial of voriconazole?

☐ Yes. 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. Please describe why the member is not a candidate for voriconazole.

2. Has the member had a trial of posaconazole?

☐ Yes. 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. Please describe why the member is not a candidate for posaconazole.

Section VII. Please complete for Cresemba IV and posaconazole IV.

Please provide medical necessity for use of IV formulation instead of oral formulations.

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Section VIII. Please complete for Cresemba for Zygomycosis (mucormycosis).

1. Has the member had a trial of posaconazole?

   ☐ Yes. 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. Please describe why the member is not a candidate for posaconazole.

Section IX. Please complete for Brexafemme and Vivjoa for vulvovaginal candidiasis (VVC).

For Brexafemme requests for a diagnosis of acute VVC, please complete questions 1 and 2. For Brexafemme requests for a diagnosis of recurrent VVC, please complete questions 1 through 5. For Vivjoa requests, please complete question 1 and questions 2 through 6.

1. Has the member had a trial of oral fluconazole?

   ☐ Yes. 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. Please describe why the member is not a candidate for oral fluconazole.

2. Is the member post-menarchal? ☐ Yes ☐ No
3. Please attach results from a potassium hydroxide (KOH) test to confirm diagnosis.
4. Has the member had ≥ three acute VVC episodes within past 12 months? ☐ Yes ☐ No
5. Is the member not of reproductive potential? ☐ Yes ☐ No
6. Is the member post-menopausal? ☐ Yes ☐ No

Section X. Please complete for Rezzayo.

1. Has the member had a trial of Eraxis?

   ☐ Yes. 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. Please describe why the member is not a candidate for Eraxis.

2. Has the member had a trial of caspofungin?

   ☐ Yes. 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. Please describe why the member is not a candidate for caspofungin.

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3. Has the member had a trial of micafungin?

☐ Yes. 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. Please describe why the member is not a candidate for micafungin.

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.)