



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
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<input type="checkbox"/> 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)

<input type="checkbox"/> 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
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<input type="checkbox"/> Health New England Online Prior Authorization: go.covermyeds.com/OptumRx Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545

<input type="checkbox"/> 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

<input type="checkbox"/> Tufts Health Plan Online Prior Authorization: point32health.promptpa.com Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985
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<input type="checkbox"/> 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 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

Leukotrienes

montelukast granules zafirlukast zileuton extended-release Zyflo (zileuton)

Other

roflumilast tablet Ofev (nintedanib) pirfenidone

Dose and frequency of medication requested

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

- | | |
|---|--|
| <input type="checkbox"/> Allergic Rhinitis (montelukast only) | <input type="checkbox"/> Exercise-Induced Bronchospasm |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Idiopathic Pulmonary Fibrosis |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (roflumilast tablet only) | <input type="checkbox"/> Systemic sclerosis-associated interstitial lung disease (SSc-ILD) |
| <input type="checkbox"/> Chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype | <input type="checkbox"/> Other <input type="text"/> |

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

Section I. Please complete for montelukast granule requests.

- Has the member had a trial with montelukast chewable tablet?
 Yes. Please list the drug names, dates/duration of trials, and outcomes below.*
 No. Please describe why montelukast chewable tablet is not appropriate for this member.
- For the diagnosis of allergic rhinitis, has the member had a trial with an intranasal antihistamine or intranasal corticosteroid and one oral second-generation antihistamines (e.g., cetirizine, loratadine)?
 Yes. Please list the drug names, dates/duration of trials, and outcomes below.*
 No. Please describe why intranasal antihistamines and corticosteroids, and oral second-generation antihistamines are not appropriate for this member.
- For the diagnosis of exercise-induced bronchospasm, has the member had a trial with inhaled albuterol, levalbuterol, or low dose inhaled corticosteroid-formoterol (e.g., budesonide/formoterol or Dulera [mometasone/formoterol])?
 Yes. Please list the drug names, dates/duration of trials, and outcomes below.*
 No. Please describe why inhaled albuterol, levalbuterol, or low dose inhaled corticosteroid-formoterol is not appropriate for this member.

Please provide details for the previous trials.

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

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

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

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

Section II. Please complete for roflumilast tablet requests.

1. Has the member had a trial with a long-acting bronchodilator (e.g., long-acting beta-agonist, long-acting anticholinergic) within the past four months?

Yes. Please list the drug name, dates/duration of trials, 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.

No. Please describe why long-acting bronchodilators are not appropriate for this member.

2. Has the member had a trial with an inhaled corticosteroid within the past four months?

Yes. Please list the drug name, dates/duration of trials, 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.

No. Please describe why inhaled corticosteroids are not appropriate for this member.

Section III. Please complete for zileuton extended-release and Zylflo requests.

1. Has the member had a trial with montelukast or zafirlukast?

Yes. Please list the drug name, dates/duration of trials, 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.

No. Please describe why montelukast and zafirlukast are not appropriate for this member.

2. For requests for zileuton extended-release, has the member had a trial with Zylflo?

Yes. Please describe the dates/duration of trial and outcomes below.*

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 describe why Zylflo is not appropriate for this member.

Section IV. Please complete for Ofev requests for a diagnosis of SSc-ILD.

Has the member had a trial with cyclophosphamide or mycophenolate?

Yes. Please list the drug name, dates/duration of trials, 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.

No. Please describe why cyclophosphamide and mycophenolate are not appropriate for this member.

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

Section V. 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.)