



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

<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

<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

<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

Targeted Immunomodulators

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

Anti-TNFs

- Abrilada (adalimumab-afzb)
- adalimumab-aacf, unbranded
- adalimumab-fkjp, unbranded
- adalimumab-adaz, unbranded
- adalimumab-adbm, unbranded
- Amjevita (adalimumab-atto)
- Avsola (infliximab-axxq)
- Cimzia (certolizumab)
- Cyltezo (adalimumab-adbm)
- Enbrel (etanercept)
- Hadlima (adalimumab-bwwd)
- Hulio (adalimumab-fkjp)
- Humira (adalimumab)
- Hyrimoz (adalimumab-adaz)
- Idacio (adalimumab-aacf)
- Inflectra (infliximab-dyyb)
- infliximab, unbranded
- Remicade (infliximab)
- Renflexis (infliximab-abda)
- Simponi (golimumab)
- Simponi Aria (golimumab for infusion)
- Yuflyma (adalimumab-aaty)
- Yusimry (adalimumab-aqvh)

Interleukin Antagonists

- Actemra (tocilizumab auto-injection, prefilled syringe)
- Actemra (tocilizumab vial) ^{MB}
- Adbry (tralokinumab-ldrm)
- Arcalyst (rilonacept)
- Cosentyx (secukinumab)
- Ilaris (canakinumab)
- Ilumya (tildrakizumab-asmn)
- Kevzara (sarilumab)
- Kineret (anakinra)
- Siliq (brodalumab)
- Skyrizi (risankizumab-rzaa)
- Spevigo (spesolimab-sbzo)
- Stelara (ustekinumab 45 mg/0.5 mL prefilled syringe, 90 mg/mL prefilled syringe, 45 mg/0.5 mL vial)
- Stelara (ustekinumab 130 mg/26 mL vial) ^{MB}
- Taltz (ixekizumab)
- Tremfya (guselkumab)

Oral Janus Kinase Inhibitors

- Cibinqo (abrocitinib)
- Litfulo (ritlecitinib)
- Olumiant (baricitinib)
- Rinvoq (upadacitinib)
- Xeljanz (tofacitinib)
- Xeljanz XR (tofacitinib extended-release)

Miscellaneous Agents

- Entyvio (vedolizumab)
- Orencia (abatacept auto-injection, prefilled syringe)
- Orencia (abatacept vial) ^{MB}
- Otezla (apremilast)
- Sotyktu (deucravacitinib)

Dose, frequency, and duration of medication requested

^{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.

Please complete the following for all requests.

1. Member's current weight

2. 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

3. Is the member stabilized on the requested medication?

Yes. Please provide start date. No

4. Please indicate prescriber specialty below.

Allergy/Immunology Dermatology Gastroenterology Rheumatology Other

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

- | | | |
|-----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Acute graft versus host disease (aGVHD) prophylaxis | <input type="checkbox"/> Giant cell arteritis (GCA) | <input type="checkbox"/> Oral ulcers associated with Behcet's disease |
| <input type="checkbox"/> Adult-onset Still's disease (AOSD) | <input type="checkbox"/> Generalized Pustular Psoriasis Flares | <input type="checkbox"/> Plaque psoriasis (PsO) |
| <input type="checkbox"/> Alopecia areata | <input type="checkbox"/> Hidradenitis suppurativa (HS) (Hurley Stage II or III) | <input type="checkbox"/> Polymyalgia rheumatica (PMR) |
| <input type="checkbox"/> Ankylosing spondylitis (AS) | <input type="checkbox"/> Hyperimmunoglobulin D syndrome (HIDS)/mevalonate kinase deficiency (MKD) | <input type="checkbox"/> Psoriatic arthritis (PsA) |
| <input type="checkbox"/> Atopic dermatitis | <input type="checkbox"/> Juvenile idiopathic arthritis (JIA) <input type="checkbox"/> Polyarticular <input type="checkbox"/> Systemic | <input type="checkbox"/> Recurrent pericarditis |
| <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Fistulizing Crohn's disease | <input type="checkbox"/> Muckle-Wells syndrome (MWS) | <input type="checkbox"/> Rheumatoid arthritis (RA) |
| <input type="checkbox"/> Cytokine release syndrome | <input type="checkbox"/> Neonatal-onset multisystem inflammatory disease (NOMID) | <input type="checkbox"/> Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD) |
| <input type="checkbox"/> Deficiency of interleukin-1 receptor antagonist (DIRA) | <input type="checkbox"/> Non-infectious uveitis | <input type="checkbox"/> Tumor necrosis factor receptor associated periodic syndrome (TRAPS) |
| <input type="checkbox"/> Enthesitis-related arthritis (ERA) | <input type="checkbox"/> Non-radiographic axial spondyloarthritis (nr-AxSpA) | <input type="checkbox"/> Ulcerative colitis (UC) |
| <input type="checkbox"/> Familial cold autoinflammatory syndrome (FCAS) | | <input type="checkbox"/> Other <input type="text"/> |
| <input type="checkbox"/> Familial Mediterranean fever (FMF) | | |

Please specify severity of indication below.

Mild Mild-moderate Moderate Moderate-severe Severe

Section I. Please complete for all requests, except for a diagnosis of aGVHD prophylaxis, alopecia areata, atopic dermatitis, AOSD, cytokine release syndrome, DIRA, FCAS, FMF, GCA, Generalized Pustular Psoriasis Flares, HIDS/MKD, HS (Hurley Stage II or III), MWS, NOMID, non-infectious uveitis, nr-AxSpA, oral ulcers associated with Behcet's disease, PMR, SSc-ILD, or TRAPS.

Has the member tried traditional or biologic disease modifying antirheumatic drugs (DMARDs)?[‡]

Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XV below.*

No. Please explain why not.

[‡] For requests for Cimzia, all infliximab products, and Simponi, please provide clinical rationale for use instead of Enbrel and Humira, if applicable. For requests for Remicade, please provide clinical rationale for use instead of unbranded infliximab.

For requests for Inflectra or Renflexis, please provide clinical rationale for use instead of unbranded infliximab and Avsola.

For requests for all adalimumab products (except Humira), please also complete section XIV.

For requests for Olumiant or Rinvoq, please document a trial with Xeljanz or Xeljanz XR, or provide clinical rationale for use of the requested agent instead of both Xeljanz and Xeljanz XR, if applicable.

For requests for Cosentyx, Ilumya, Siliq, Skyrizi, and Tremfya, please document a trial with Stelara, or provide clinical rationale for use of the requested agent instead of Stelara and Taltz, if applicable.

For requests for Stelara and Taltz for a diagnosis of PsA, a trials with a traditional or biologic DMARDs is not required.

Section II. Please also complete for treatment of PsO with any adalimumab product, Avsola, Cimzia, Cosentyx, Enbrel, Ilumya, Inflectra, Otezla, Remicade, Renflexis, Siliq, Skyrizi, Stelara, Taltz, Tremfya, or unbranded infliximab.

Has the member tried other therapies to treat this condition including topical agents, systemic agents, and phototherapy?

Yes. Please list the names of the therapies, dates/duration of trials, and outcomes in Section XV below.*

No. Please explain why not.

Section III. Please also complete for treatment of AS with anti-TNFs, Cosentyx, Rinvoq, Taltz, Xeljanz, and Xeljanz XR, and for treatment of nr-AxSpA with Cimzia, Cosentyx, Rinvoq, and Taltz.

1. Has the member tried two nonsteroidal anti-inflammatory drugs (NSAIDs)?

Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XV below.*

No. Please explain why not.

2. If the request is for Cosentyx, Rinvoq, Xeljanz, or Xeljanz XR for the treatment of AS, has the member tried one anti-TNF agent that is FDA-approved for AS?

Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XV below.*

No. Please explain why not.

3. If the request is for Cosentyx for the treatment of AS, has the member tried Taltz?

Yes. Please list the drug name, dates/duration of trial, and outcome in Section XV below.*

No. Please explain why not.

4. If the request is for Cosentyx or Rinvoq for the treatment of nr-AxSpA, has the member tried one anti-TNF agent?

Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XV below.*

No. Please explain why not.

5. If the request is for Cosentyx or Rinvoq for the treatment of nr-AxSpA, has the member tried Taltz?

Yes. Please list the drug name, dates/duration of trial, and outcome in Section XV below.*

No. Please explain why not.

Section IV. Please complete for treatment of cytokine release syndrome with Actemra IV.

Please provide anticipated date of administration with concurrent CAR T-cell therapy.

Section V. Please complete for treatment of non-infectious uveitis with Humira and for treatment of GCA with Actemra.

Has the member tried other medications to treat this condition including glucocorticoid therapy for Actemra, or glucocorticoid and immunosuppressive therapy for Humira?

Yes. Please list the drug name, dates/duration of trials, and outcomes in Section XV below.*

No. Please explain why not.

Section VI. Please complete for treatment of SSc-ILD with Actemra SC.

Has the member tried cyclophosphamide or mycophenolate?

Yes. Please list the drug name, dates/duration of trials, and outcomes in Section XV below.*

No. Please explain why not.

Section VII. Please complete for treatment of DIRA with Arcalyst and Kineret.

1. Has the diagnosis been confirmed through genetic testing? Yes. No.

2. If the request is for Arcalyst, has the member tried Kineret?

Yes. Please list the drug name, dates/duration of trial, and outcome in Section XV below.*

No. Please explain why not.

Section VIII. Please complete for treatment FCAS and MWS with Arcalyst and Ilaris and for treatment of FMF, HIDS/MKD, and TRAPS with Ilaris.

1. Has the diagnosis been confirmed through genetic testing? Yes. No.

If no, does the member have evidence of symptoms indicative of the disease?

Yes. Please explain.

No

2. If the request is for treatment of FCAS and MWS with Arcalyst, has the member tried Ilaris?

Yes. Please list the drug name, dates/duration of trial, and outcome in Section XV below.*

No. Please explain why not.

3. If the request is for treatment of FMF with Ilaris, has the member tried colchicine?

Yes. Please list the drug name, dates/duration of trial, and outcome in Section XV below.*

No. Please explain why not.

Section IX. Please complete for treatment of AOSD and systemic JIA with Ilaris, and for treatment of recurrent pericarditis with Arcalyst.

1. Has the member tried other medications to treat this condition, including corticosteroids and Kineret?

Yes. Please list the drug name, dates/duration of trials, and outcomes in Section XV below.*

No. Please explain why not.

2. If the request is for treatment of recurrent pericarditis with Arcalyst, has the member tried colchicine and NSAIDs or aspirin?

Yes. Please list the drug name, dates/duration of trial, and outcome in Section XV below.*

No. Please explain why not.

Section X. Please complete for aGVHD prophylaxis with Orencia.

1. Will the requested agent be used in combination with a calcineurin inhibitor?

Yes. Please list drug name, dose, and frequency below.

Drug name

Dose and frequency

No. Please explain.

2. Will the requested agent be used in combination with methotrexate?

Yes. Please list dose and frequency.

No. Please explain.

Section XI. Please complete for treatment of atopic dermatitis with Adbry, Cibinqo, and Rinvoq.

1. Has the member tried a superpotent or potent topical corticosteroid to treat this condition?
 Yes. Please list the drug name, dates/duration of trial, and outcome in Section XV below.*
 No. Please explain why not.
2. Has the member tried topical tacrolimus or Eucrisa to treat this condition?
 Yes. Please list the drug name, dates/duration of trial, and outcome in Section XV below.*
 No. Please explain why not.
3. For Cibinqo and Rinvoq, has the member tried Dupixent to treat this condition?
 Yes. Please list the drug name, dates/duration of trial, and outcome in Section XV below.*
 No. Please explain why not.

Section XII. Please complete for treatment of alopecia areata with Litfulo and Olumiant.

Has the member tried other medications to treat this condition, including a topical corticosteroid, an intralesional corticosteroid, and Xeljanz or Xeljanz XR?

- Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XV below.*
 No. Please explain why not.

Section XIII. Please complete for treatment of polymyalgia rheumatica with Kevzara.

1. Has the member tried a systemic corticosteroid to treat this condition?
 Yes. Please list the drug name, dates/duration of trial, and outcome in Section XV below.*
 No. Please explain why not.
2. Has the member tried methotrexate to treat this condition?
 Yes. Please list the drug name, dates/duration of trial, and outcome in Section XV below.*
 No. Please explain why not.

Section XIV. Please also complete for Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Yuflyma, Yusimry, and unbranded adalimumab generic requests.

Has the member had a trial with Humira?

- Yes. Please attach medical records documenting an inadequate response or adverse reaction to Humira.
 No. Please document clinical rationale for use of the requested agent instead of Humira.

Section XV. Please complete for all requests as needed.

Please provide the following information regarding previous trials.*

Drug name/Therapy 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.

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Briefly describe details of adverse reaction or inadequate response.

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Drug name/Therapy 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.

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

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

Please describe the clinical rationale for exceeding the quantity limit.

Section XVII. 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.)