Print Clear

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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T-cell Immunotherapies
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

- ☐ Abecma (idecabtagene vicleucel)[MB]
- ☐ Breyanzi (lisocabtagene maraleucel)[MB]
- ☐ Carvykti (ciltacabtagene autoleucel)[MB]
- ☐ Columvi (glofitamab-gxbm)[MB]
- ☐ Epkinly (epcoritamab-bysp)[MB]
- ☐ Lunsumio (mosunetuzumab-axgb)[MB]
- ☐ Kymriah (tisagenlecleucel)[MB]
- ☐ Tecartus (brexucabtagene autoleucel)[MB]
- ☐ Tecvayli (teclistamab-cqyv) [MB]
- ☐ Yescarta (axicabtagene ciloleucel)[MB]

[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

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

‡ Abecma and Carvykti requests only
†† Breyanzi requests only
§§ Columvi requests only
**** Epkinly requests only**
*** Kymriah requests only**
‖ Lunsumio requests only
† Tecartus requests only
± Tecvayli requests only
§ Yescarta requests only

- ☐ B-cell precursor acute lymphoblastic leukemia (ALL) that is refractory or in second or later relapse *
- ☐ Large B-cell lymphoma that is refractory to first-line chemoimmunotherapy or that relapses within 12 months of first-line chemoimmunotherapy §
- ☐ Relapsed or refractory follicular lymphoma (FL) after two or more lines of systemic therapy * § ‖
- ☐ Relapsed or refractory large B-cell lymphoma after two or more lines of systemic therapy, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified (NOS), high grade B-cell lymphoma, and DLBCL arising from FL*
- ☐ Relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL) †
- ☐ Relapsed or refractory large B-cell lymphoma after two or more lines of systemic therapy, including DLBCL NOS, primary mediastinal large B-cell lymphoma, high grade B-cell lymphoma, and DLBCL arising from FL §
- ☐ Relapsed or refractory DLBCL NOS, DLBCL arising from indolent lymphoma, DLBCL arising from high-grade B-cell lymphoma **
- ☐ Relapsed or refractory large B-cell lymphoma, including DLBCL NOS (including DLBCL arising from indolent lymphoma), high-grade B-cell lymphoma, primary mediastinal large B-cell lymphoma, and FL grade 3B ††
  - ☐ Refractory disease to first-line chemoimmunotherapy or relapse within 12 months of first-line chemoimmunotherapy

☐ Relapsed or refractory DLBCL, not otherwise specified or LBCL arising from follicular lymphoma §§

☐ Refractory disease to first-line chemoimmunotherapy or relapse after first-line chemoimmunotherapy and are not eligible for hematopoietic stem cell transplantation [HSCT] due to comorbidities or age

☐ Relapsed or refractory mantle cell lymphoma (MCL)†

☐ Relapse or refractory disease after two or more lines of systemic therapy

☐ Relapsed or refractory multiple myeloma after four or more prior lines of therapy, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 monoclonal antibody ‡ ±

Please indicate prescriber specialty below.

☐ Hematology ☐ Oncology ☐ Other

Section I. Please complete for all requests.

1. Member's current weight Date
2. Please indicate billing preference. ☐ 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. Please provide anticipated dates for the following as applicable.
   Treatment date Leukapheresis Admission Infusion Discharge
4. Please provide the infusion setting. ☐ Inpatient ☐ Outpatient
5. Will the infusion take place in a health care facility that has been certified pursuant to the Risk Evaluation and Mitigation Strategy (REMS) program specific to the treatment being provided? ☐ Yes ☐ No
6. Please list any other prior trials including the drug names, dates/duration of use, and outcomes below. Please note, Abecma, Carvykti, and Tecvayli are FDA-approved for use after four or more lines of therapy, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 monoclonal antibody. *
   Drug Dates/duration ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   Drug Dates/duration ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   Drug Dates/duration ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   Drug Dates/duration ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
7. Outreach for both short- and long-term monitoring for efficacy and durability of response will be conducted by MassHealth. The applicable information [including but not limited to: medical records, dates of procedures, infusions, and admissions; adverse reactions experienced; agents used to treat adverse reactions; response to therapy (e.g. complete blood count, bone marrow blasts, peripheral blood blasts, platelets, absolute neutrophil counts)] will be provided to MassHealth upon request. ☐ Yes ☐ No

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Section II. Please also complete for Kymriah requests for a diagnosis of B-cell precursor acute lymphoblastic leukemia (ALL) that is refractory or in second or later relapse.

1. Please indicate Philadelphia chromosome type. ☐ Positive ☐ Negative
   If positive, has the member failed two kinase inhibitors? ☐ Yes. Please provide details below.* ☐ No
   Drug _____ Dates/duration _____ Outcome _____
   Drug _____ Dates/duration _____ Outcome _____
2. Does the member have refractory disease? ☐ Yes ☐ No
3. Please provide the number of relapses. _____

Section III. Please also complete for Tecartus requests for a diagnosis of relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL).

1. Please indicate Philadelphia chromosome type. ☐ Positive ☐ Negative
   If positive, has the member failed one tyrosine kinase inhibitor? ☐ Yes. Please provide details below.* ☐ No
   Drug _____ Dates/duration _____ Outcome _____
2. Does the member have primary refractory disease? ☐ Yes ☐ No
3. Please provide the number of relapses. _____ Dates/duration _____
4. Did the member receive an allogeneic stem cell transplant? ☐ Yes ☐ No Date _____

**Attach a letter with additional information regarding medication trials as applicable.*

Section IV. 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.
   _____
   _____

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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.)