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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**<br>Pharmacy: Fax: (877) 208-7428 - Tel: (800) 745-7318 |
| **MassHealth Managed Care Organization (MCO) and Accountable Care Partnership Plans (ACPP)** |
| ☐ **Fallon Health**<br>Online Prior Authorization: go.covermymeds.com/OptumRx<br>Online Prior Authorization: providerportal.surescripts.net/ProviderPortal/optum<br>Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033 |
| ☐ **Health New England**<br>Online Prior Authorization: go.covermymeds.com/OptumRx<br>Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545 |
| ☐ **Mass General Brigham Health Plan**<br>Online Prior Authorization (Non-Specialty Drugs): go.covermymeds.com/OptumRx<br>Online Prior Authorization (Specialty/Medical Drugs): provider.massgeneralbrighamhealthplan.org<br>Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555 |
| ☐ **Tufts Health Plan**<br>Online Prior Authorization: point32health.promptpa.com<br>Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985 |
| ☐ **WellSense Health Plan**<br>Online Prior Authorization: wellsense.org/providers/ma/pharmacy/prior-authorizations<br>Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822 |

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# Thrombocytopenic 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**

- ☐ Cablivi (caplacizumab-yhdp)
- ☐ Doptelet (avatrombopag)
- ☐ Mulpleta (lusutrombopag)
- ☐ Nplate (romiplostim) [MB]
- ☐ Promacta (eltrombopag)
- ☐ Tavalisse (fostamatinib)

**Dose and frequency** _____ **Duration of therapy** _____

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 _____

[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.*

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

- ☐ Acquired thrombotic thrombocytopenic purpura (aTTP)
- ☐ Chronic, relapsed, or refractory immune thrombocytopenia (ITP)
- ☐ Hematopoietic Syndrome of Acute Radiation Syndrome (HS-ARS)/Acute exposure to myelosuppressive doses of radiation
- ☐ Severe aplastic anemia
- ☐ Thrombocytopenia due to chronic liver disease (CLD)
- ☐ Thrombocytopenia in the setting of hepatitis C
- ☐ Other _____

## Section I. Please complete for Doptelet and Mulpleta requests for thrombocytopenia due to chronic liver disease.

1. Is a procedure planned? ☐ Yes. Please provide anticipated date of procedure. _____ ☐ No
2. Please provide date and results of most recent platelet count (including laboratory reference ranges).
   _____
3. For Mulpleta requests, has the member had a trial with Doptelet?
   ☐ Yes. Please list the dates/duration of use and outcomes below.
   Dates/duration of use _____ ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Please explain why not. _____

**Section II. Please complete for Doptelet, Nplate, Promacta, and Tavalisse requests for chronic, relapsed or refractory ITP.**

1. Please provide date and results of most recent platelet count (including laboratory reference ranges). For platelet count > 30,000 cells/mcL, describe medical necessity for platelet elevation.

Has the member had a trial with a corticosteroid or immunoglobulin therapy?
☐ Yes. Please list the drug name, 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.

☐ No. Please explain why not.

2. Has the member had a splenectomy? ☐ Yes ☐ No
3. For Doptelet, Nplate, and Tavalisse requests, has the member had a trial with Promacta?
☐ Yes. Please list the dates/duration of use and outcomes below.

Dates/duration of use ☐ Adverse reaction ☐ Inadequate response ☐ Other
Briefly describe details of adverse reaction, inadequate response, or other.

☐ No. Please explain why not.

**Section III. Please complete for Promacta requests for thrombocytopenia in the setting of hepatitis C.**

1. Please provide date and results of most recent platelet count (including laboratory reference ranges).
2. Is the member currently on interferon therapy? ☐ Yes. Please provide start date. ☐ No
3. For members not currently on interferon therapy, does the treatment plan include initiation of therapy with interferon? ☐ Yes ☐ No

**Section IV. Please complete for Promacta requests for severe aplastic anemia.**

1. Please provide date and results of most recent platelet count (including laboratory reference ranges).
2. Has the member had a trial with anti-thymocyte globulin (ATG)?
☐ Yes. Please list the dates/duration of use and outcomes below.

Dates/duration of use ☐ Adverse reaction ☐ Inadequate response ☐ Other
Briefly describe details of adverse reaction, inadequate response, or other.

☐ No. Please explain why not.

3. Has the member had a trial with cyclosporine?
☐ Yes. Please list the dates/duration of use and outcomes below.

Dates/duration of use ☐ Adverse reaction ☐ Inadequate response ☐ Other

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

☐ No. Please explain why not.

4. For use of Promacta in combination with ATG and cyclosporine, please provide clinical rationale.

## Section V. Please complete for Cablivi requests.

Will the member be taking the requested medication concurrently with immunosuppressive therapy?

☐ Yes. Please list the drug name and dates/duration of use.

Drug name Dates/duration of use

☐ No. Please explain why not.

## 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

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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.)