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

over

Beta Thalassemia, Myelodysplastic Syndrome, and Sickle Cell Disease 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

- ☐ Adakveo (crizanlizumab-tmca)[MB]
- ☐ Casgevy (exagamglogene autotemcel) [MB]
- ☐ Endari (l-glutamine)
- ☐ Oxbryta (voxelotor)
- ☐ Reblozyl (luspatercept-aamt)[MB]
- ☐ Siklos (hydroxyurea tablet)
- ☐ Zynteglo (betibeglogene autotemcel)[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.)

- ☐ Beta Thalassemia (provide documentation of genetic testing)
- ☐ Myelodysplastic syndromes associated anemia
- ☐ Sickle Cell Disease (SCD)
- ☐ Other

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

Is the prescriber a hematologist?

- ☐ Yes
- ☐ No. Please attach consultation notes from a hematologist addressing the use of the requested agent.

Member's current weight Date

Section I. Please complete for Adakveo and Oxbryta requests.

1. Has the member experienced sickle cell crises in the last 12 months (two or more for Adakveo and at least one or more for Oxbryta)?

   ☐ Yes. Please provide dates. ☐ No
2. Has the member had an inadequate response to hydroxyurea for at least three months? Please note: Trial will be evaluated to ensure titration to maximally tolerated dose.*

☐ Yes. Please note: Requests will be evaluated taking into account MassHealth pharmacy claims history or additional documentation addressing adherence to this agent.

Dose and frequency _____ Dates of use _____ Outcome _____

Please attach hematologic laboratory data (e.g., absolute neutrophil count [ANC], platelet count, hemoglobin, reticulocyte count) supporting dosing regimen.

☐ No

3. Has the member tried hydroxyurea and had an adverse reaction or does the member have a contraindication to this agent?*

☐ Yes. Please explain. _____ ☐ No

4. For Oxbryta requests, please document current hemoglobin (Hb). _____ Date Hb obtained _____
5. For Oxbryta 300 mg tablet for oral suspension requests, please document medical necessity for the requested formulation.

_____

6. For Adakveo recertification requests, please attach medical records documenting positive response to therapy (e.g., follow up information on vasoocclusive crises, pain management, hospitalizations, and/or member's improvement).
7. For Oxbryta recertification requests, please attach medical records documenting positive response to therapy (e.g., follow up information on vasoocclusive crises, Hb level, laboratory markers associated with hemolysis, and/or member's improvement).

Section II. Please complete for Endari requests.

1. Has the member experienced two or more sickle cell crises in the last 12 months?

☐ Yes. Please provide dates. _____ ☐ No

2. Has the member had a trial with hydroxyurea?*

☐ 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 Reblozyl for beta thalassemia requests.

1. Please attach a copy of genetic test confirming diagnosis of beta thalassemia.
2. Is the member transfusion-dependent?

☐ Yes. Please attach medical records supporting regular blood transfusions and/or chronic iron chelator use.

☐ No

3. For recertification requests, please attach medical records documenting positive response to therapy (e.g., follow up information on transfusion requirements and/or member's improvement).

Section IV. Please complete for Siklos requests.

Please document medical necessity for the use of tablet formulation.

_____

_____

over

Section V. Please complete for Zynteglo requests.

1. Please attach a copy of genetic test confirming diagnosis of beta thalassemia.
2. Is the member transfusion-dependent?
   ☐ Yes. Please attach medical records supporting regular blood transfusions.
   ☐ No
3. Please provide anticipated dates and dosing for the following as applicable.
   Apheresis ____ Admission ____ Infusion ____ Dose ____ Discharge ____
4. Does the member have pre-existing human immunodeficiency virus (HIV), hepatitis B virus (HBV), or hepatitis C virus (HCV) infection? ☐ Yes. Please describe. ____ ☐ No
5. Has the member required ≥100 mL/kg/year of pRBC or ≥ eight transfusions within the last 12 months?
   ☐ Yes. Please describe. ____ ☐ No
6. Will the infusion take place in a qualified treatment center? ☐ Yes ____ ☐ No
7. Is the member clinically stable and eligible for hematopoietic stem cell transplantation (HSCT)? ☐ Yes ☐ No
8. 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., necessity of pRBC transfusions, including date, frequency, volume, reason for transfusion (e.g., planned procedure, accident, low hemoglobin level, etc.)]) will be provided to MassHealth upon request.
   ☐ Yes ☐ No

Section VI. Please complete for Casgevy requests.

1. Please attach a copy of genetic test confirming diagnosis of SCD.
2. Has the member experienced at least two sickle cell crises per year in the last two years?
   ☐ Yes. Please provide dates. ____ ☐ No
3. Has the member had an inadequate response to hydroxyurea for at least three months? Please note: Trial will be evaluated to ensure titration to maximally tolerated dose.*
   ☐ Yes. Please note: Requests will be evaluated taking into account MassHealth pharmacy claims history or additional documentation addressing adherence to this agent.
   Dose and frequency ____ Dates of use ____ Outcome ____
   Please attach hematologic laboratory data (e.g., absolute neutrophil count [ANC], platelet count, hemoglobin, reticulocyte count) supporting dosing regimen.
   ☐ No
4. Please provide anticipated dates and dosing for the following as applicable.
   Apheresis ____ Admission ____ Infusion ____ Dose ____ Discharge ____
5. Will the infusion take place in a qualified treatment center? ☐ Yes ____ ☐ No
6. Is the member clinically stable and eligible for hematopoietic stem cell transplantation (HSCT)? ☐ Yes ☐ No
7. Does the member have active human immunodeficiency virus (HIV), hepatitis B virus (HBV), or hepatitis C virus (HCV) infection? ☐ Yes. Please describe. ____ ☐ No
8. Has the member received any prior SCD gene therapy?
   ☐ Yes. Please describe. ____ ☐ No

over

Section VII. 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.

over

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.)