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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** 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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Osteoporosis Agents and Calcium Regulators
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

Bisphosphonates

- ☐ alendronate solution
- ☐ Binosto (alendronate effervescent tablet)
- ☐ Fosamax Plus D (alendronate/cholecalciferol)
- ☐ ibandronate IV
- ☐ risedronate
- ☐ risedronate delayed-release

Miscellaneous Agents

- ☐ calcitonin salmon injection
- ☐ Evenity (romosozumab-aqqg)
- ☐ Prolia (denosumab)
- ☐ teriparatide 620 mcg/2.48 mL
- ☐ teriparatide 600 mcg/2.4 mL
- ☐ Tymlos (abaloparatide)
- ☐ Xgeva (denosumab)

Dose, frequency, and duration of medication requested

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

- ☐ Giant cell tumor of the bone (Xgeva) (Section VIII)
- ☐ Glucocorticoid-Induced Osteoporosis (GIO) (Section II)
- ☐ Hypercalcemia
- ☐ Hypercalcemia of malignancy (Xgeva) (Section VII)
- ☐ Hypocalcemia with hypoparathyroidism
- ☐ Osteopenia
- ☐ Paget's Disease
- ☐ Postmenopausal Osteoporosis (PMO)
- ☐ Prevention of bone loss in men receiving androgen deprivation therapy for prostate cancer
- ☐ Prevention of bone loss in women receiving aromatase inhibitors for breast cancer
- ☐ Prevention of skeletal-related events secondary to bone metastases in cancer related to solid tumors (Xgeva) (Section VII)
- ☐ Prevention of skeletal-related events secondary to multiple myeloma (Xgeva) (Section VII)
- ☐ Primary/Hypogonadal Osteoporosis
- ☐ 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

Section I. Please complete for bisphosphonates, Prolia, teriparatide 600 mcg/2.4 mL, and teriparatide 620 mcg/2.48 mL as indicated above.

1. Please provide results of bone mineral density (BMD) measurements (T-scores of total hip and lumbar vertebrae).

2. Has the member had a radiographically confirmed fracture?
   ☐ Yes. Please provide site and date below.
   Site _____ Date _____
   ☐ No
3. Please list all non-modifiable risk factors for fracture in this member.
   _____
4. Has the member tried an oral bisphosphonate and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please list the dates/duration of oral bisphosphonate trial and outcomes in Section IX below.*
   ☐ No. Please document if there is a contraindication to oral bisphosphonates.
   _____
5. If the request is for teriparatide 600 mcg/2.4 mL or teriparatide 620 mcg/2.48 mL, has the member tried Prolia or an intravenous bisphosphonate and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please list the drug names, dates/duration of trials and outcomes in Section IX below.*
   ☐ No. Please document if there is a contraindication to Prolia and intravenous bisphosphonates.
   _____

Section II. Please complete for all agents being requested for the treatment or prevention of Glucocorticoid-Induced Osteoporosis (GIO).

Please provide specifics of the member's chronic glucocorticoid use.

Drug _____ Dose and Frequency _____ Dates/Duration _____

Section III. Please complete for calcitonin salmon injection, Evenity, and Tymlos requests.

Please attach supporting documentation of the diagnosis, BMD measurements, medical necessity for the requested agent, fracture risk factors, and previous trials including oral bisphosphonates, IV bisphosphonates (ibandronate, pamidronate, zoledronic acid 5 mg), or Prolia as applicable. For Evenity and Tymlos requests, please also attach supporting documentation of previous trials including teriparatide 600 mcg/2.4 mL as applicable. For calcitonin salmon injection, please also attach supporting documentation of previous trials including teriparatide 600 mcg/2.4 mL and calcitonin nasal spray as applicable.

Section IV. Please complete for teriparatide 620 mcg/2.48 mL requests.

Please provide medical necessity for the use of teriparatide 620 mcg/2.48 mL instead of teriparatide 600 mcg/2.4 mL . _____

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Section V. Please complete for Fosamax Plus D requests.

Please provide medical necessity for the combination product instead of the individual agents.

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Section VI. Please complete for Xgeva requests for a diagnosis of prevention of skeletal-related events secondary to bone metastases in cancer related to solid tumors, prevention of skeletal-related events secondary to multiple myeloma, and hypercalcemia of malignancy.

Please indicate prescriber specialty below.

☐ Hematology ☐ Oncology ☐ Orthopedic Specialist ☐ Other

If prescriber is not a specialist, please attach consult notes from specialist.

Section VII. Please complete for Xgeva requests for a diagnosis of giant cell tumor of the bone.

Please describe surgical history and/or prognosis. If surgery is not appropriate for this member, please explain.

Section VIII. Please complete for alendronate solution and Binosto requests.

Does the member have a medical condition in which they are unable to swallow tablets/capsules?

☐ Yes. (Please list reason.)

☐ No. (Please provide clinical rationale why conventional dosage forms cannot be used.)

Section IX. 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.

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 X. 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.

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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.

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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

E-mail 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.