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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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Ophthalmic Anti-Allergy and Anti-Inflammatory 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

Ophthalmic Anti-Allergy Agents (Section I)

- ☐ Zerviate (cetirizine ophthalmic solution)

Ophthalmic Corticosteroids (Section III)

- ☐ Eysuvis (loteprednol 0.25% suspension)
- ☐ Inveltys (loteprednol 1% suspension)
- ☐ Lotemax SM (loteprednol 0.38% gel)

Ophthalmic Non-Steroidal Anti-Inflammatory Agents (Section II)

- ☐ bromfenac 0.075%
- ☐ bromfenac 0.09%
- ☐ Ilevro (nepafenac 0.3% ophthalmic solution)
- ☐ Cequa (cyclosporine 0.09% ophthalmic solution) (Section IV)

Miscellaneous

- ☐ Miebo (perfluorohexyloctane) (Section IV)
- ☐ Restasis Multidose (cyclosporine multidose 0.05% ophthalmic emulsion) (Section IV)
- ☐ Tyrvaya (varenicline nasal spray) (Section IV)
- ☐ Verkazia (cyclosporine 0.1% ophthalmic emulsion) (Section V)
- ☐ Vevye (cyclosporine 0.1% ophthalmic solution) (Section VI)
- ☐ Xdemvy (lotilaner)
- ☐ Xiidra (lifitegrast) (Section IV)

Other Medication

- ☐ Other* _____

**If request is for a non-preferred brand name or generic product, please attach supporting documentation (e.g., copies of medical records and/or office notes regarding adverse reaction or inadequate response to the preferred product).*

Dose, frequency, and duration of medication requested _____

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

- ☐ Allergic conjunctivitis (seasonal or perennial)
- ☐ Demodex Blepharitis
- ☐ Keratoconjunctivitis sicca
- ☐ Post-operative pain and/or inflammation following ocular surgery
- ☐ Vernal conjunctivitis and/or vernal keratitis
- ☐ Other (Please indicate.) _____

Symptoms and symptom frequency _____

Section I. Please complete for Zerviate requests.

For members ≥ two to < three years of age, please complete question 1. For members ≥ three years of age, please complete question 2.

1. Has the member had a trial with two of the following: Alomide, bepotastine, epinastine, or olopatadine ophthalmic solution?
   - ☐ Yes. Please list the drug names, dates/duration of trials and outcomes below.*

   Drug name _____ Dates/duration of trial _____

Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
Briefly describe details of adverse reaction, inadequate response, or other.

Drug name Dates/duration of trial
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 if there is a contraindication to these trials.

2. Has the member had a trial with two of the following: Alocril, Alomide, azelastine ophthalmic solution, bepotastine, epinastine, ketotifen, or olopatadine ophthalmic solution?
   ☐ Yes. Please list the drug names, dates/duration of trials and outcomes below.*

   Drug name Dates/duration of trial
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.

   Drug name Dates/duration of trial
   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 if there is a contraindication to these trials.

Section II. Please complete for all requests for ophthalmic non-steroidal anti-inflammatory agents.

Has the member had a trial with ophthalmic diclofenac, flurbiprofen, ketorolac, or nepafenac 0.1%?
☐ Yes. Please list the drug name, dates/duration of trials and outcomes below.*

Drug name Dates/duration of trial
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 if there is a contraindication to these trials.

Section III. Please complete for all requests for ophthalmic corticosteroids.

1. For Eysuvis, has the member had a trial with a topical corticosteroid for ophthalmic use that is available without prior authorization?
   ☐ Yes. Please list the drug name, dates/duration of trials and outcomes below.*

   Drug name Dates/duration of trial
   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 if there is a contraindication to this trial.
2. For Eysuvis, has the member had a trial with cyclosporine 0.05% ophthalmic emulsion?

   ☐ Yes. Please list the dates/duration of trials and outcomes.* Dates/duration of trial

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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 if there is a contraindication to this trial.

For Inveltys and Lotemax SM, has the member had a trial with loteprednol 0.5% suspension, gel or ointment?

☐ Yes. Please list the dates/duration of trials and outcomes.* Dates/duration of trial
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 if there is a contraindication to this trial.

Section IV. Please complete for all requests for Cequa, Miebo, Restasis Multidose, Tyrvaya, and Xiidra.

1. Has the member had a trial with cyclosporine 0.05% ophthalmic emulsion?

   ☐ Yes. Please list the dates/duration of trials and outcomes.* Dates/duration of trial
   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 if there is a contraindication to this trial.
2. For Restasis Multidose, please provide medical necessity for the use of the requested formulation instead of cyclosporine 0.05% ophthalmic emulsion (single use vial formulation).
3. For Miebo and Tyrvaya, has the member had a trial with Xiidra?

   ☐ Yes. Please list the dates/duration of trials and outcomes.* Dates/duration of trial
   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 if there is a contraindication to this trial.

Section V. Please complete for all requests for Verkazia.

1. Has the member had a trial with ophthalmic azelastine, epinastine, ketotifen, or olopatadine?
   ☐ Yes. Please list the drug name, dates/duration of trials and outcomes below.*
   Drug name Dates/duration of trial
   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 if there is a contraindication to these trials.
2. Has the member had a trial with a topical corticosteroid for ophthalmic use?
   ☐ Yes. Please list the drug name, dates/duration of trials and outcomes below.*
   Drug name Dates/duration of trial

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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 if there is a contraindication to this trial.

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

Section VI. Please complete for all requests for Vevye.

1. Has the member had a trial with ophthalmic cyclosporine 0.05% emulsion?
   ☐ Yes. Please list dates/duration of use and outcomes below.*
   Dates/duration of trial Outcome
   ☐ No. Please document if there is a contraindication to ophthalmic cyclosporine 0.05% emulsion.
2. Has the member had a trial with ophthalmic cyclosporine 0.09% emulsion?
   ☐ Yes. Please list dates/duration of use and outcomes below.*
   Dates/duration of trial Outcome
   ☐ No. Please document if there is a contraindication to ophthalmic cyclosporine 0.09% emulsion.
3. Has the member had a trial with Tyrvaya?
   ☐ Yes. Please list dates/duration of use and outcomes below.*
   Dates/duration of trial Outcome
   ☐ No. Please document if there is a contraindication to Tyrvaya.
4. Has the member had a trial with Xiidra?
   ☐ Yes. Please list dates/duration of use and outcomes below.*
   Dates/duration of trial Outcome
   ☐ No. Please document if there is a contraindication to Xiidra.

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

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.

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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

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.)