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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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# Oral Respiratory 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**

**Leukotrienes**

☐ montelukast granules ☐ zafirlukast ☐ zileuton extended-release ☐ Zyflo (zileuton)

**Other**

☐ roflumilast tablet ☐ Ofev (nintedanib) ☐ pirfenidone

**Dose and frequency of medication requested**

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

☐ Allergic Rhinitis (montelukast only)
☐ Asthma
☐ Chronic Obstructive Pulmonary Disease (roflumilast tablet only)
☐ Chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype
☐ Exercise-Induced Bronchospasm
☐ Idiopathic Pulmonary Fibrosis
☐ Systemic sclerosis-associated interstitial lung disease (SSc-ILD)
☐ Other

Please list all other medications currently prescribed for the member for this indication.

## Section I. Please complete for montelukast granule requests.

1. Has the member had a trial with montelukast chewable tablet?.
   ☐ Yes. Please list the drug names, dates/duration of trials, and outcomes below.*
   ☐ No. Please describe why montelukast chewable tablet is not appropriate for this member.
2. For the diagnosis of allergic rhinitis, has the member had a trial with an intranasal antihistamine or intranasal corticosteroid and one oral second-generation antihistamines (e.g., cetirizine, loratadine)?
   ☐ Yes. Please list the drug names, dates/duration of trials, and outcomes below.*
   ☐ No. Please describe why intranasal antihistamines and corticosteroids, and oral second-generation antihistamines are not appropriate for this member.
3. For the diagnosis of exercise-induced bronchospasm, has the member had a trial with inhaled albuterol, levalbuterol, or low dose inhaled corticosteroid-formoterol (e.g., budesonide/formoterol or Dulera [mometasone/formoterol])?
   ☐ Yes. Please list the drug names, dates/duration of trials, and outcomes below.*
   ☐ No. Please describe why inhaled albuterol, levalbuterol, or low dose inhaled corticosteroid-formoterol is not appropriate for this member.

Please provide details for the previous trials.

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.

_____

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.

_____

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.

_____

## Section II. Please complete for roflumilast tablet requests.

1. Has the member had a trial with Anoro, Bevespi, Duaklir, or Stiolto within the past four months?

   ☐ Yes. Please list the drug name, dates/duration of trials, 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 describe why Anoro, Bevespi, Duaklir, and Stiolto are not appropriate for this member.

   _____

2. Has the member had a trial with Breztri or Trelegy within the past four months?

   ☐ Yes. Please list the drug name, dates/duration of trials, 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 describe why Breztri and Trelegy are not appropriate for this member.

   _____

## Section III. Please complete for zileuton extended-release and Zyflo requests.

1. Has the member had a trial with montelukast or zafirlukast?

   ☐ Yes. Please list the drug name, dates/duration of trials, 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 describe why montelukast and zafirlukast are not appropriate for this member.

   _____

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2. For requests for zileuton extended-release, has the member had a trial with Zyflo?

☐ Yes. Please describe the dates/duration of trial and outcomes below*.

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 describe why Zyflo is not appropriate for this member.

## Section IV. Please complete for Ofev requests for a diagnosis of SSc-ILD.

Has the member had a trial with cyclophosphamide or mycophenolate?

☐ Yes. Please list the drug name, dates/duration of trials, 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 describe why cyclophosphamide and mycophenolate are not appropriate for this member.

**Please attach a letter documenting additional trials as necessary*

## Section V. 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

E-mail address

Telephone No.*

Fax No.* (Please provide fax number for PA response notification.)

** 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

## Provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am either the prescribing provider or duly authorized to act on behalf of the provider identified in the Prescriber information section of this form. Any attached statement on 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.

**Signature of provider or individual duly authorized to act on behalf of the provider:**

Printed legal name and title of signatory above

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.)