



# 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.

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

# Cystic Fibrosis Agents

## Prior Authorization Request

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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](http://www.mass.gov/druglist).

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### Medication information

**Medication requested** (Where applicable, the brand name is provided in brackets for reference.)

- |  |   |
|--|---|
| <input type="checkbox"/> Bronchitol (mannitol inhalation powder) | <input type="checkbox"/> Tobi Podhaler (tobramycin inhalation powder) |
| <input type="checkbox"/> Kalydeco (ivacaftor)                    | <input type="checkbox"/> tobramycin inhalation solution [Bethkis]     |
| <input type="checkbox"/> Orkambi (lumacaftor/ivacaftor)          | <input type="checkbox"/> tobramycin inhalation solution [Kitabis Pak] |
| <input type="checkbox"/> Symdeko (tezacaftor/ivacaftor)          | <input type="checkbox"/> Trikafta (elexacaftor/tezacaftor/ivacaftor)  |

**Dose, frequency, and duration of medication requested**

**Is the member stabilized on the requested medication?**  Yes. Please provide start date.   No

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

Cystic Fibrosis [Please specify genetic mutation(s) below.]

Does the member have *Pseudomonas aeruginosa*?  Yes  No

Other

Is this member a referral candidate for care coordination?  Yes  No

If yes, MassHealth will offer care coordination services to this member. Please describe which additional behavioral health services would be beneficial. *Please inform the member, parent, or legal guardian to expect outreach from a MassHealth representative of care coordination services.*

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### Section I. Please complete for initial requests for Kalydeco, Orkambi, Symdeko, and Trikafta.

1. Please document member's baseline body mass index (BMI).  Date
  2. For members > 6 years of age, please document member's baseline percent predicted forced expiratory volume in one second (ppFEV1).  Date
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### Section II. Please complete for recertification requests for Kalydeco, Orkambi, Symdeko, and Trikafta.

1. Please document member's current BMI.  Date   
Has the member demonstrated an improvement in BMI?  Yes  No
2. For members > 6 years of age, please document member's current ppFEV1.  
 Date   
Has the member demonstrated an improvement in lung function?  Yes  No

3. Has the member demonstrated a reduced frequency of clinical exacerbations since initiating the requested medication?  Yes  No

If yes, please describe.

4. If member has not demonstrated improvement in the ppFEV1, BMI or frequency of clinical exacerbations, please document response to therapy.

**Section III. Please complete for Tobi Podhaler and tobramycin inhalation solution (generic Bethkis and Kitabis Pak) requests.**

Has the member had a trial with tobramycin inhalation solution (generic Tobi)?

Yes. Please list the dose and frequency, dates/duration of trials, and outcomes below.

Dose and frequency  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.

**Section IV. Please complete for Bronchitol requests.**

1. Documentation that member has passed the Bronchitol Tolerance Test  Yes  No

2. Has the member had a trial with Pulmozyme?

Yes. Please list the dose and frequency, dates/duration of trials, and outcomes below.

Dose and frequency  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.

3. Has the member had a trial with sodium chloride for inhalation?

Yes. Please list the dose and frequency, dates/duration of trials, and outcomes below.

Dose and frequency  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 V. Please include any other pertinent information (if needed).**

**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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**Please continue to next page and complete Prescriber and Provider Information section.**

# Prior Authorization Request Prescriber and Provider Information

## Prescriber information

Last name*	<input type="text"/>	First name*	<input type="text"/>	MI	<input type="text"/>
NPI*	<input type="text"/>	Individual MH Provider ID	<input type="text"/>		
DEA No.	<input type="text"/>	Office Contact Name	<input type="text"/>		
Address	<input type="text"/>	City	<input type="text"/>	State	<input type="text"/>
		Zip	<input type="text"/>		
E-mail address	<input type="text"/>				
Telephone No.*	<input type="text"/>				
Fax No.* (Please provide fax number for PA response notification.)	<input type="text"/>				

\* Required

## Please also complete for professionally administered medications, if applicable.

Start date	<input type="text"/>	End date	<input type="text"/>		
Servicing prescriber/facility name	<input type="text"/>	<input type="checkbox"/>	Same as prescribing provider		
Servicing provider/facility address	<input type="text"/>				
Servicing provider NPI/tax ID No.	<input type="text"/>				
Name of billing provider	<input type="text"/>				
Billing provider NPI No.	<input type="text"/>				
Is this a request for recertification?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
CPT code	<input type="text"/>	No. of visits	<input type="text"/>	J code	<input type="text"/>
				No. of units	<input type="text"/>

## 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

<input type="text"/>	Date	<input type="text"/>
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(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.)