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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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Dermatological Agents (Topical Chemotherapy and Genital Wart Therapy) 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 requested

☐ Ameluz (aminolevulinic acid) [MB]
☐ imiquimod 3.75% cream
☐ Levulan (aminolevulinic acid) [MB]
☐ Veregen (sinecatechins)
☐ Ycanth (cantharidin) [MB]
☐ Zyclara (imiquimod 2.5% cream)

[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, PA does not apply through the hospital outpatient and inpatient settings. Please refer to 130 CMR 433.408 for PA 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 PA status and criteria, if applicable.*

Dose, frequency, and duration of medication requested

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

☐ Actinic keratosis
  ☐ Face ☐ Scalp ☐ Upper extremities
☐ External genital warts
☐ Perianal warts
☐ Molluscum contagiosum
☐ Other
(Attach a letter regarding medical necessity.)

Please indicate billing preference. ☐ Pharmacy ☐ Prescriber in-office ☐ Hospital outpatient
If applicable, please also complete section for professionally administered medications at end of form.

Is the prescriber a dermatologist?
☐ Yes
☐ No. For Ameluz, Levulan, and Ycanth requests, please attach consultation notes from a dermatologist addressing the use of the requested agent.

Section I. Please complete for treatment of actinic keratosis with imiquimod 3.75% cream, or Zyclara.

1. Has the member had a trial with topical fluorouracil?
   ☐ Yes. Please list the dates/duration of use and outcomes below.
   Dates/duration ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   ☐ No. Please document if there is a contraindication to topical fluorouracil therapy.
2. If the request is for imiquimod 3.75% cream or Zyclara, has the member tried imiquimod 5% cream?
   ☐ Yes. Please list the dates/duration of use and outcomes below.

Dates/duration ☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

☐ No. Please document if there is a contraindication to imiquimod 5% cream.

Section II. Please complete for Ameluz and Levulan requests.

1. Has the member had a trial with topical fluorouracil or topical imiquimod?
   ☐ Yes. Please list the drug name, dates/duration of use, and outcomes below.

   Drug name

   Dates/duration ☐ Adverse reaction ☐ Inadequate response ☐ Other

   Briefly describe details of adverse reaction, inadequate response, or other.

   ☐ No. Please document if there is a contraindication to topical fluorouracil and topical imiquimod.
2. Has the member tried and failed cryosurgery? ☐ Yes ☐ No
3. Will the requested agent be used in conjunction with photodynamic therapy? ☐ Yes ☐ No
4. If the request is for Ameluz, has the member had a trial with Levulan used in conjunction with photodynamic therapy?
   ☐ Yes. Please list the dates/duration of use and outcomes below.

   Dates/duration ☐ Adverse reaction ☐ Inadequate response ☐ Other

   Briefly describe details of adverse reaction, inadequate response, or other.

   ☐ No. Please document if there is a contraindication to Levulan used in conjunction with photodynamic therapy.

Section III. Please complete for Ycanth requests.

1. Has the member had a trial with topical podofilox?
   ☐ Yes. Please list the dates/duration of use and outcomes below.

   Dates/duration ☐ Adverse reaction ☐ Inadequate response ☐ Other

   Briefly describe details of adverse reaction, inadequate response, or other.

   ☐ No. Please document if there is a contraindication to topical podofilox.
2. Has the member tried and failed cryotherapy? ☐ Yes ☐ No
3. Has the member tried and failed curettage? ☐ Yes ☐ No

Section IV. Please complete for treatment of external genital warts or perianal warts with imiquimod 3.75% cream or Veregen.

1. Has the member had a trial with topical podofilox, or podophyllum resin applied by a provider?
   ☐ Yes. Please list the drug name, dates/duration of use, and outcomes below.

   Drug name

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Dates/duration ☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

☐ No. Please document if there is a contraindication to topical podofilox and podophyllum resin.

2. If the request is for imiquimod 3.75% cream, has the member had a trial with imiquimod 5% cream?

Dates/duration ☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

☐ No. Please document if there is a contraindication to imiquimod 5% cream.

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.

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.)