



# 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.

<p><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></p> <p><input type="checkbox"/> <b>MassHealth Drug Utilization Review Program</b> Pharmacy: Fax: (877) 208-7428 - Tel: (800) 745-7318</p>
<p><b>MassHealth Managed Care Organization (MCO) and Accountable Care Partnership Plans (ACPP)</b></p> <p><input type="checkbox"/> <b>Fallon Health</b> Online Prior Authorization: <a href="http://go.covermy meds.com/OptumRx">go.covermy meds.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</p>
<p><input type="checkbox"/> <b>Health New England</b> Online Prior Authorization: <a href="http://go.covermy meds.com/OptumRx">go.covermy meds.com/OptumRx</a> Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545</p>
<p><input type="checkbox"/> <b>Mass General Brigham Health Plan</b> Online Prior Authorization (Non-Specialty Drugs): <a href="http://go.covermy meds.com/OptumRx">go.covermy meds.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</p>
<p><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</p>
<p><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</p>

# Gonadotropin-Releasing Hormone 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](http://www.mass.gov/druglist).

## Medication information

### Medication requested

- |  |   |
|--|---|
| <input type="checkbox"/> Camcevi (leuprolide)                          | <input type="checkbox"/> Orgovyx (relugolix)                        |
| <input type="checkbox"/> Eligard (leuprolide)                          | <input type="checkbox"/> Oriahnn (elagolix/estradiol/norethindrone) |
| <input type="checkbox"/> Fensolvi (leuprolide) <sup>MB</sup>           | <input type="checkbox"/> Orilissa (elagolix)                        |
| <input type="checkbox"/> Firmagon (degarelix)                          | <input type="checkbox"/> Supprelin LA (histrelin) <sup>MB</sup>     |
| <input type="checkbox"/> leuprolide 22.5 mg vial                       | <input type="checkbox"/> Synarel (nafarelin)                        |
| <input type="checkbox"/> Lupron (leuprolide)                           | <input type="checkbox"/> Trelstar (triptorelin) <sup>MB</sup>       |
| <input type="checkbox"/> Myfembree (relugolix/estradiol/norethindrone) | <input type="checkbox"/> Triptodur (triptorelin)                    |

<sup>MB</sup> 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 include ICD-10 code, if applicable.)

- |   |  |
|---|--|
| <input type="checkbox"/> Advanced breast cancer   | <input type="checkbox"/> Idiopathic or neurogenic central precocious puberty (CPP) |
| <input type="checkbox"/> Advanced prostate cancer   | <input type="checkbox"/> Uterine leiomyomata (fibroids)                            |
| <input type="checkbox"/> Endometrial thinning prior to ablation for abnormal uterine bleeding | <input type="checkbox"/> Other <input type="text"/>                                |
| <input type="checkbox"/> Endometriosis  |  |
| <input type="checkbox"/> Gender Dysphoria   |  |

Please indicate billing preference.  Pharmacy  Prescriber in-office  Hospital outpatient

If applicable, please also complete section for professionally administered medications at end of form.

## Section I. Please complete for requests for idiopathic or neurogenic CPP.

1. Provide age of secondary sex characteristics onset.
2. Is the member under the care of a pediatric endocrinologist?  
 Yes. Name of member's pediatric endocrinologist  Date of last visit   
 No. Please attach medical records of a consultation with a pediatric endocrinologist.
3. For members  $\geq 11$  years of age and  $< 12$  years of age (female sex assigned at birth/biologic females) or  $\geq 12$  years of age and  $< 13$  years of age (male sex assigned at birth/biologic males), does the member require one additional year of prolonged therapy due to developmental delay?  Yes.  No.

4. For Fensolvi and Triptodur, has the member tried Lupron Ped and experienced an adverse reaction or inadequate response?

Yes. Please provide date and outcome for trial.

Date(s)  Outcome(s)

No. Please explain.

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**Section II. Please complete for requests for endometriosis.**

1. Has the member tried non-steroidal anti-inflammatory drugs (NSAIDs) and experienced an adverse reaction or inadequate response?

Yes. Provide drug names, dates, and outcomes for trials below.

Drug name(s)  Date(s)  Outcome(s)

No. Please explain if there is a contraindication to this trial.

2. Has the member tried hormonal contraceptives and experienced an adverse reaction or inadequate response?

Yes. Provide drug names, dates, and outcomes for trials below.

Drug name(s)  Date(s)  Outcome(s)

No. Please explain if there is a contraindication to this trial.

3. For Myfembree and Orilissa, has the member tried Lupron and experienced an adverse reaction or inadequate response?

Yes. Please provide date and outcome for trial.

Date(s)  Outcome(s)

No. Please explain if there is a contraindication to this trial.

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**Section III. Please complete for requests for endometrial thinning prior to ablation for abnormal uterine bleeding and uterine leiomyomata (fibroids).**

1. Is surgery planned?

Yes. Please provide anticipated date of surgery.

No. Please explain.

2. Has the member tried hormonal contraceptives and experienced an adverse reaction or inadequate response?

Yes. Please provide date and outcome for trial.

Date(s)  Outcome(s)

No. Please explain.

3. For Myfembree and Oriahhn, has the member tried Lupron and experienced an adverse reaction or inadequate response?

Yes. Please provide date and outcome for trial.

Date(s)  Outcome(s)

No. Please explain.

4. For Myfembree, has the member tried Oriahhn and experienced an adverse reaction or inadequate response?

Yes. Please provide date and outcome for trial.

Date(s)  Outcome(s)

No. Please explain.

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**Section IV. Please complete for requests for advanced prostate cancer.**

1. Please indicate prescriber specialty.  Oncology  Urology  Other
2. For Lupron Depot 7.5 mg, Lupron Depot 22.5 mg, Lupron Depot 30 mg or Lupron Depot 45 mg, please describe clinical rationale for use instead of the equivalent dose of Eligard.

  

3. For Orgovyx, has the member tried Eligard, leuprolide 22.5 mg vial, or Lupron Depot and experienced an adverse reaction or inadequate response?

Yes. Provide drug names, dates, and outcomes for trials below.

Drug name(s)  Date(s)  Outcome(s)

No. Please explain.

4. For Orgovyx, has the member tried Firmagon and experienced an adverse reaction or inadequate response?

Yes. Please provide date and outcome for trial.

Date(s)  Outcome(s)

No. Please explain.

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**Section V. Please complete for requests for gender dysphoria.**

For Lupron 7.5 mg, 22.5 mg, 30 mg, and 45 mg adult kit, please describe clinical rationale for use instead of the equivalent dose of Eligard.

  
  

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**Section VI. Please complete for all other diagnoses, excluding advanced breast cancer.**

Please describe the medical necessity for the use of gonadotropin-releasing hormone, including previous trials and outcomes, and dates of any relevant lab tests (including but not limited to bone mineral density).

  
  

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**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.


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.)