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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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Pulmonary Hypertension
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 (Check one or all that apply. Where applicable, the brand name is provided in brackets for reference.)

- ☐ Adempas (riociguat)
- ☐ ambrisentan
- ☐ bosentan
- ☐ epoprostenol [Veletri]
- ☐ Liqrev (sildenafil oral suspension)
- ☐ Opsumit (macitentan)
- ☐ Opsynvi (macitentan/tadalafil)
- ☐ Orenitram (treprostinil extended-release tablet)
- ☐ sildenafil 20 mg tablet
- ☐ sildenafil oral suspension [Revatio]
- ☐ tadalafil tablet
- ☐ Tadliq (tadalafil suspension)
- ☐ treprostinil injection
- ☐ Tyvaso (treprostinil inhalation solution)
- ☐ Tyvaso DPI (treprostinil inhalation powder)
- ☐ Uptravi (selexipag)
- ☐ Ventavis (iloprost inhalation)
- ☐ Winrevair (sotatercept-csrk)
- ☐ 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

Is the member stabilized on the requested medication?

☐ Yes. Please provide start date. ☐ No

Section I. Please complete for all requests.

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

- ☐ Chronic thromboembolic pulmonary hypertension (CTEPH)
- ☐ Pulmonary arterial hypertension (PAH)
- ☐ Pulmonary hypertension associated with interstitial lung disease (PH-ILD)
- ☐ Other (Please indicate.)

Please indicate prescriber specialty below.

☐ Cardiology ☐ Pulmonology ☐ Other (Please indicate.)

Please attach copies of medical records and/or office notes from cardiologist or pulmonologist regarding the diagnosis.

Section II. Please also complete for tadalafil tablet and Tadliq requests.

1. Has the member tried sildenafil 20 mg tablet?
   ☐ Yes. Please provide the following information.*

   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.

☐ No. Does the member have a contraindication to sildenafil? Please explain.

2. Is the member treatment naïve? ☐ Yes ☐ No
   If yes, will the requested agent be used in combination with ambrisentan? ☐ Yes ☐ No
3. Will the requested agent be administered concurrently with Adempas? ☐ Yes. Please explain below. ☐ No
4. For Tadliq, please provide medical necessity for the use of the requested formulation instead of tadalafil tablet.

Section III. Please also complete for Adempas requests.

1. Will Adempas be administered concurrently with a phosphodiesterase-5 inhibitor (sildenafil or tadalafil)?
   ☐ Yes. Please explain below. ☐ No
2. For members with CTEPH, please describe surgical history and/or prognosis.
3. For members with pulmonary arterial hypertension, has the member tried sildenafil or tadalafil?
   ☐ Yes. Please provide the following information.*
   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.
   ☐ No. Does the member have a contraindication to sildenafil and tadalafil? Please explain.

Section IV. Please also complete for Orenitram, treprostinil injection, Tyvaso, Tyvaso DPI, and Ventavis for PAH requests.

Has the member tried epoprostenol (Veletri) or Flolan?
☐ Yes. Please provide the following information.*
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.
☐ No. Does the member have a contraindication to epoprostenol (Veletri) or Flolan? Please explain.

Section V. Please also complete for Tyvaso DPI for PH-ILD requests.

Please attach medical records documenting inadequate response, adverse reaction, or contraindication to Tyvaso inhalation solution.

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Section VI. Please also complete for epoprostenol (Veletri) requests.

Has the member tried Flolan?

☐ Yes. Please provide the following information.*

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.

☐ No. Does the member have a contraindication to Flolan? Please explain.

Section VII. Please also complete for Liqrev, sildenafil 20 mg tablet and oral suspension [Revatio] requests.

1. Will sildenafil be administered concurrently with Adempas? ☐ Yes. Please explain below. ☐ No
2. For Liqrev and sildenafil oral suspension [Revatio], please provide medical necessity for the use of the requested formulation instead of sildenafil tablet.
3. For Liqrev, please provide medical necessity for the use of the requested formulation instead of sildenafil oral suspension [Revatio].

* Please attach a letter documenting additional trials as necessary.

Section VIII. Please also complete for bosentan for suspension requests.

Member's current weight Date

Section IX. Please also complete for Uptravi vial requests.

1. Is the member stabilized on Uptravi tablets?

   ☐ Yes. Please provide start date. ☐ No
2. Is the member temporarily unable to take oral medications?

   ☐ Yes. Please explain.

   ☐ No

Section X. Please also complete for Opsynvi requests.

1. Please provide medical necessity for the use of the combination product instead of the commercially available separate agents.

5. Will the requested agent be administered concurrently with Adempas? ☐ Yes. Please explain below. ☐ No

Section XI. Please also complete for Winrevair requests.

1. Member's current weight Date
2. Please document member's current WHO functional class. ☐ I ☐ II ☐ III ☐ IV

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3. Is the member stable on background therapy for PAH? ☐ Yes. ☐ No.
4. For recertification requests, please attach medical records documenting a positive response to therapy.

Section XII. 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.)