Print Clear

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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Neuromuscular 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

- ☐ Amondys 45 (casimersen)
- ☐ Duvyzat (givinostat)
- ☐ Elevidys (delandistrogene moxeparvovec-rokl) [MB]
- ☐ Evrysdi (risdiplam)
- ☐ Exondys 51 (eteplirsen)
- ☐ Spinraza (nusinersen) [MB]
- ☐ Viltepso (viltolarsen)
- ☐ Vyondys 53 (golodirsen)
- ☐ Zolgensma (onasemnogene abeparvovec-xioi) [MB]

[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 include ICD-10 code, if applicable.)

- ☐ Duchenne muscular dystrophy (DMD)
- ☐ Other
- ☐ Spinal muscular atrophy (SMA)
  - ☐ pre-symptomatic ☐ symptomatic
  - Type

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

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

Drug NDC (if known) or service code

Member's current weight Date

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

Section I. Please complete for Amondys 45, Duvyzat, Exondys 51, Viltepso, and Vyondys 53 requests.

For initial requests, please complete questions 1 through 12 as applicable. For recertification requests, please complete questions 3, 7, 9, 10, 11, and 12 as applicable.

1. Please attach laboratory testing results of a confirmed out-of-frame deletion in the DMD gene that is amenable to either exon 45 skipping (for Amondys 45 requests), exon 51 skipping (for Exondys 51 requests) or exon 53 skipping (for Viltepso and Vyondys 53 requests). For Duvyzat, attach a copy of genetic test showing mutation in the DMD gene confirming the diagnosis.
2. Is the prescriber a neuromuscular neurologist? ☐ Yes ☐ No. If no, please attach consultation notes from a neuromuscular neurologist addressing the use of the requested agent.

3. Is the member ambulatory as defined by a current six-minute walk test (6MWT-distance walked in six minutes in meters) of ≥ 200 meters?
   Please note, the test must have been observed or completed by the treating provider, or ordered by the treating provider and completed by a qualified medical practitioner.

   ☐ Yes. Distance _____ meters ☐ No

   Date of performance _____ Treatment at the time of test _____
4. For Amondys 45, Exondys 51 and Vyondys 53 requests, has the member received a corticosteroid for at least six months prior to use with the requested agent?
   ☐ Yes. Please list the drug name, dose and frequency, and dates of use below.

   Drug name _____ Dose and frequency _____ Dates of use _____

   ☐ No. Please explain. _____
5. For Viltepso requests, has the member received a corticosteroid for at least three months prior to use with the requested agent?
   ☐ Yes. Please list the drug name, dose and frequency, and dates of use below.

   Drug name _____ Dose and frequency _____ Dates of use _____

   ☐ No. Please explain. _____
6. For Duvyzat requests, is the member on a stable dose of corticosteroid?
   ☐ Yes. Please list the drug name, dose and frequency, and dates of use below.

   Drug name _____ Dose and frequency _____ Dates of use _____

   ☐ No
7. Will the member be taking the requested agent concurrently with a corticosteroid?
   ☐ Yes. Please document drug name with dose and frequency below.

   Drug name _____ Dose and frequency _____

   ☐ No. Please explain. _____
8. Please provide dates and measurements and attach medical records of baseline measurements for each of the following five timed function tests: timed 10-meter walk/run, timed floor (supine) to stand, timed four-step descend, timed four-step climb, timed sit to stand. Medical records must include the times in seconds, dates of performances, and treatment at the time of tests. Please note, the test must have been observed or completed by the treating provider, or ordered by the treating provider and completed by a qualified medical practitioner.

   Timed 10-meter walk/run (time in seconds) _____

   Date of performance _____ Treatment at the time of test _____

   Timed floor (supine) to stand (time in seconds) _____

   Date of performance _____ Treatment at the time of test _____

   Timed four-step descend (time in seconds) _____

   Date of performance _____ Treatment at the time of test _____

   Timed four-step climb (time in seconds) _____

   Date of performance _____ Treatment at the time of test _____

   Timed sit to stand (time in seconds) _____

   Date of performance _____ Treatment at the time of test _____

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9. Please provide dates and measurements and attach medical records of all previous and current six-minute walk tests (6MWTs). Please note, the current test must have been observed or completed by the treating provider, or ordered by the treating provider and completed by a qualified medical practitioner.
   Baseline 6MWT
   Distance _____ meters
   Date of performance _____ Treatment at the time of test _____
   Current 6MWT
   Distance _____ meters
   Date of performance _____ Treatment at the time of test _____
   Additional 6MWT(s)
   Date(s) of performance _____
10. Please provide dates and measurements and attach medical records of current measurements for each of the following five timed function tests: timed 10-meter walk/run, timed floor (supine) to stand, timed four-step descend, timed four-step climb, timed sit to stand. Medical records must include the times in seconds, dates of performances, and treatment at the time of tests. Please note, the test must have been observed or completed by the treating provider, or ordered by the treating provider and completed by a qualified medical practitioner.
    Timed 10-meter walk/run (time in seconds) _____
    Date of performance _____ Treatment at the time of test _____
    Timed floor (supine) to stand (time in seconds) _____
    Date of performance _____ Treatment at the time of test _____
    Timed four-step descend (time in seconds) _____
    Date of performance _____ Treatment at the time of test _____
    Timed four-step climb (time in seconds) _____
    Date of performance _____ Treatment at the time of test _____
    Timed sit to stand (time in seconds) _____
    Date of performance _____ Treatment at the time of test _____
11. Has the member previously received treatment with a gene therapy for DMD? ☐ Yes ☐ No
12. For Duvyzat requests, will the requested agent be used in combination with other disease-modifying therapies for DMD (e.g., exon-skipping therapies)? ☐ Yes ☐ No

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Section II. Please complete for Evrysdi and Spinraza requests.

1. Please attach a copy of genetic test(s) confirming the diagnosis of SMA and SMN2 copy number.
2. Is the member symptomatic? ☐ Yes ☐ No
3. Is the member a pre-symptomatic infant diagnosed via newborn screening? ☐ Yes ☐ No
4. Is the prescriber a neurologist? ☐ Yes ☐ No. If no, please attach consultation notes from a neurologist addressing the use of the requested agent.
5. Please attach documentation of current motor function test.
6. Will the requested agent be used in combination with other agents for SMA?
   ☐ Yes. Please provide drug name(s). _____
   ☐ No

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7. For initial and recertification requests, does the member have evidence of permanent ventilator, defined as any of the following?
   Member has an endotracheal tube ☐ Yes ☐ No
   Member has a tracheotomy tube ☐ Yes ☐ No
   Member has at least 14 days of continuous respiratory assistance for at least 16 hours per day ☐ Yes ☐ No
8. Has the member been previously treated with any other SMA agent? ☐ Yes ☐ No
   If yes, please list the drug names and outcomes below.
   Drug name _____ ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
9. For members previously treated with another SMA agent, please attach documentation of pre-treatment baseline motor function tests and post-treatment motor function tests.
10. For members previously treated with Zolgensma, please attach pre-Zolgensma baseline motor function test (if different than the pre-treatment tests) and post-treatment motor function tests.
11. For recertification requests, please attach medical records documenting positive response to therapy (e.g., follow up information on motor function tests and/or member's improvement or stability of function).

Section III. Please complete for Zolgensma requests.

Please note, questions 7, 8, and 9 will not impact the outcome of review for approval of Zolgensma.

1. Please attach a copy of the genetic test confirming diagnosis of SMA and number of copies of SMN2 gene.
2. Is the prescriber a neuromuscular specialist? ☐ Yes ☐ No. If no, please attach the consultation notes from a neuromuscular specialist addressing the use of the requested agent.
3. Please attach a copy of baseline AAV9 antibody test.
4. Pre-treatment baseline Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND) score. _____
5. Does the member have evidence of complete paralysis of limbs? ☐ Yes ☐ No
6. Does the member have evidence of permanent ventilator dependence at the time Zolgensma is to be administered, defined as any of the following?
   Member has an endotracheal tube ☐ Yes ☐ No
   Member has a tracheotomy tube ☐ Yes ☐ No
   Member has at least 14 days of continuous respiratory assistance for at least 16 hours per day ☐ Yes ☐ No
7. Has the member had a trial with Spinraza? ☐ Yes ☐ No
   If yes, please list the dose and frequency, dates of use, outcome, and treatment plan below.
   Dose and frequency _____ Dates of use _____
   Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   Will the member continue Spinraza after Zolgensma? ☐ Yes ☐ No
8. Has the member had a trial with Evrysdi? ☐ Yes ☐ No
   If yes, please list the dose and frequency, dates of use, outcome, and treatment plan below.
   Dose and frequency _____ Dates of use _____
   Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____

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Will the member continue Evrysdi after Zolgensma? ☐ Yes ☐ No

9. Please describe the functional tests that will be used to monitor this member and attach medical records with baseline functional test scores.
10. Has the member previously received treatment with a gene therapy for DMD? ☐ Yes ☐ No
11. Does the member have an active viral infection, including human immunodeficiency virus (HIV) or positive serology for hepatitis B or C, or Zika virus? ☐ Yes ☐ No

Section IV. Please complete for Elevidys requests.

1. Please attach a copy of genetic test with a confirmed mutation in the DMD gene.
2. Please attach a copy of baseline anti-AAVrh74 total binding antibody titers < 1:400.
3. Will the infusion take place in a qualified treatment center? ☐ Yes ☐ No
4. Please provide anticipated date of administration.
5. Is the prescriber a neuromuscular specialist? ☐ Yes ☐ No
6. Does the member have any deletion in exon 8 or exon 9 of the DMD gene? ☐ Yes ☐ No
7. Is the member on a stable dose of corticosteroid? ☐ Yes ☐ No
8. Will the member continue to utilize chronic corticosteroids after Elevidys infusion? ☐ Yes ☐ No
9. Does the member have a contraindication to corticosteroids? ☐ Yes ☐ No

   If yes, briefly describe details of contraindication.
10. Has the member been previously treated with a gene therapy for DMD? ☐ Yes ☐ No
11. Is the member currently utilizing antisense oligonucleotides? ☐ Yes ☐ No
12. Has the member had a baseline measurement for the North Star Ambulatory Assessment (NSAA)?
    ☐ Yes. Please attach medical records of NSAA, including scores and times on individual items. ☐ No
13. Is the member ambulatory as defined by a current 6MWT of ≥ 200 meters?
    Please note, the test must have been observed or completed by the treating provider or ordered by the treating provider and completed by a qualified medical practitioner.

    ☐ Yes. Distance meters ☐ No

    Date of performance Treatment at the time of test
14. Please provide dates and measurements and attach medical records of all previous and current six-minute walk tests (6MWTs). Please note, the current test must have been observed or completed by the treating provider, or ordered by the treating provider and completed by a qualified medical practitioner.

    Baseline 6MWT

    Distance meters

    Date of performance Treatment at the time of test

    Current 6MWT

    Distance meters

    Date of performance Treatment at the time of test

    Additional 6MWT(s)

    Date(s) of performance

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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.)