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

over

Beta Thalassemia, Myelodysplastic Syndrome, and Sickle Cell Disease 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

- ☐ Adakveo (crizanlizumab-tmca)[MB]
- ☐ Casgevy (exagamglogene autotemcel) [MB]
- ☐ l-glutamine
- ☐ Lyfgenia (lovotibeglogene autotemcel) [MB]
- ☐ Reblozyl (luspatercept-aamt) [MB]
- ☐ Rytelo (imetelstat) [MB]
- ☐ Siklos (hydroxyurea tablet)
- ☐ Zynteglo (betibeglogene autotemcel) [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.)

- ☐ Beta Thalassemia (provide documentation of genetic testing)
- ☐ Myelodysplastic syndromes associated anemia
- ☐ Sickle Cell Disease (SCD)
- ☐ Other

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

Is the prescriber a hematologist?

- ☐ Yes
- ☐ No. Please attach consultation notes from a hematologist addressing the use of the requested agent.

Member's current weight Date

Section I. Please complete for Adakveo requests.

1. Has the member experienced two or more sickle cell crises in the last 12 months?
   ☐ Yes. Please provide dates. ☐ No
2. Has the member had an inadequate response to hydroxyurea for at least three months? Please note: Trial will be evaluated to ensure titration to maximally tolerated dose.*

☐ Yes. Please note: Requests will be evaluated taking into account MassHealth pharmacy claims history or additional documentation addressing adherence to this agent.

Dose and frequency _____ Dates of use _____ Outcome _____

Please attach hematologic laboratory data (e.g., absolute neutrophil count [ANC], platelet count, hemoglobin, reticulocyte count) supporting dosing regimen.

☐ No

3. Has the member tried hydroxyurea and had an adverse reaction or does the member have a contraindication to this agent?*

☐ Yes. Please explain. _____ ☐ No

4. For recertification requests, please attach medical records documenting positive response to therapy (e.g., follow up information on vaso-occlusive crises, pain management, hospitalizations, and/or member's improvement).

Section II. Please complete for l-glutamine requests.

1. Has the member experienced two or more sickle cell crises in the last 12 months?

☐ Yes. Please provide dates. _____ ☐ No

2. Has the member had a trial with hydroxyurea?*

☐ Yes. Please list the dates/duration of use and outcomes below.

Dates/duration of use _____ ☐ Adverse reaction ☐ Inadequate response ☐ Other

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

_____

☐ No. Please explain why not. _____

Section III. Please complete for Reblozyl for beta thalassemia requests.

1. Please attach a copy of genetic test confirming diagnosis of beta thalassemia.
2. Is the member transfusion-dependent?

☐ Yes. Please attach medical records supporting regular blood transfusions and/or chronic iron chelator use.

☐ No

3. For recertification requests, please attach medical records documenting positive response to therapy (e.g., follow up information on transfusion requirements and/or member's improvement).

Section IV. Please complete for Siklos requests.

Please document medical necessity for the use of tablet formulation.

_____

_____

Section V. Please complete for Zynteglo requests.

1. Please attach a copy of genetic test confirming diagnosis of beta thalassemia.
2. Is the member transfusion-dependent?

☐ Yes. Please attach medical records supporting regular blood transfusions.

☐ No

3. Please provide anticipated dates and dosing for the following as applicable.

Apheresis _____ Admission _____ Infusion _____ Dose _____ Discharge _____

over

4. Please provide human immunodeficiency virus (HIV) serology test results.
   ☐ Positive ☐ Negative ☐ Not completed
5. Has the member required ≥100 mL/kg/year of pRBC or ≥ eight transfusions within the last 12 months?
   ☐ Yes. Please describe. _____ ☐ No
6. Will the infusion take place in a qualified treatment center? ☐ Yes _____ ☐ No
7. Is the member clinically stable and eligible for hematopoietic stem cell transplantation (HSCT)? ☐ Yes ☐ No
8. Has the member received any prior TDT gene therapy?
   ☐ Yes. Please describe. _____ ☐ No
9. Outreach for both short- and long-term monitoring for efficacy and durability of response will be conducted by MassHealth. The applicable information (including but not limited to: medical records, dates of procedures, infusions, and admissions; adverse reactions experienced; agents used to treat adverse reactions; response to therapy [e.g., necessity of pRBC transfusions, including date, frequency, volume, reason for transfusion (e.g., planned procedure, accident, low hemoglobin level, etc.)]) will be provided to MassHealth upon request.
   ☐ Yes ☐ No

Section VI. Please complete for Casgevy requests.

For a diagnosis of transfusion dependent beta thalassemia, please complete questions 1-9. For a diagnosis of sickle cell disease, please complete questions 1-8 and 10-11.

1. Please attach a copy of genetic test confirming diagnosis.
2. Please provide anticipated dates and dosing for the following as applicable.
   Apheresis _____ Admission _____ Infusion _____ Dose _____ Discharge _____
3. Will the infusion take place in a qualified treatment center? ☐ Yes _____ ☐ No
4. Will the member receive pre-infusion conditioning with busulfan? ☐ Yes ☐ No
5. Is the member clinically stable and eligible for hematopoietic stem cell transplantation (HSCT)? ☐ Yes ☐ No
6. Does the member have active human immunodeficiency virus (HIV), hepatitis B virus (HBV), or hepatitis C virus (HCV) infection? ☐ Yes. Please describe. _____ ☐ No
7. Has the member received any prior gene therapy for the requested diagnosis?
   ☐ Yes. Please describe. _____ ☐ No
8. Outreach for both short- and long-term monitoring for efficacy and durability of response will be conducted by MassHealth. The applicable information (including but not limited to: medical records, dates of procedures, hospital admissions, and emergency department visits; adverse reactions experienced; [e.g., occurrence of VOC event]) will be provided to MassHealth upon request.
   ☐ Yes ☐ No
9. For beta thalassemia, has the member required ≥100 mL/kg/year of pRBC or ≥ ten units per year within the previous two years?
   ☐ Yes. Please describe. _____ ☐ No
10. For sickle cell disease, has the member experienced at least two sickle cell crises per year in the last two years?
    ☐ Yes. Please provide dates. _____ ☐ No

over

11. For sickle cell disease, has the member had an inadequate response to hydroxyurea for at least three months? Please note: Trial will be evaluated to ensure titration to maximally tolerated dose.*
    ☐ Yes. Please note: Requests will be evaluated taking into account MassHealth pharmacy claims history or additional documentation addressing adherence to this agent.
    Dose and frequency ____ Dates of use ____ Outcome ____
    Please attach hematologic laboratory data (e.g., absolute neutrophil count [ANC], platelet count, hemoglobin, reticulocyte count) supporting dosing regimen.
    ☐ No

Section VII. Please complete for Lyfgenia requests.

1. Please attach a copy of genetic test confirming diagnosis of SCD.
2. Has the member experienced at least two sickle cell crises per year in the last two years?
   ☐ Yes. Please provide dates. ____ ☐ No
3. Has the member had an inadequate response to hydroxyurea for at least three months? Please note: Trial will be evaluated to ensure titration to maximally tolerated dose.*
   ☐ Yes. Please note: Requests will be evaluated taking into account MassHealth pharmacy claims history or additional documentation addressing adherence to this agent.
   Dose and frequency ____ Dates of use ____ Outcome ____
   Please attach hematologic laboratory data (e.g., absolute neutrophil count [ANC], platelet count, hemoglobin, reticulocyte count) supporting dosing regimen.
   ☐ No
4. Please provide anticipated dates and dosing for the following as applicable.
   Apheresis ____ Admission ____ Infusion ____ Dose ____ Discharge ____
5. Will the infusion take place in a qualified treatment center? ☐ Yes ____ ☐ No
6. Is the member clinically stable and eligible for hematopoietic stem cell transplantation (HSCT)? ☐ Yes ☐ No
7. Please provide human immunodeficiency virus (HIV) serology test results.
   ☐ Positive ☐ Negative ☐ Not completed
8. Does the member have α-thalassemia trait (-α3.7/-α3.7)? ☐ Yes. Please describe.
   ____ ☐ No
9. Please provide medical necessity for use of requested agent instead of Casgevy.
   ____
10. Has the member received any prior SCD gene therapy?
    ☐ Yes. Please describe. ____ ☐ No
11. Outreach for both short- and long-term monitoring for efficacy and durability of response will be conducted by MassHealth. The applicable information (including but not limited to: medical records, dates of procedures, hospital admissions, and emergency department visits; adverse reactions experienced; [e.g., occurrence of VOC event]) will be provided to MassHealth upon request.
    ☐ Yes ☐ No

Section VIII. Please complete for Rytelo requests.

1. Has the member required ≥ four RBC transfusions within the last eight weeks?
   ☐ Yes. Please describe. ____ ☐ No

over

2. Has the member had a trial with an erythropoiesis stimulating agent (e.g., epoetin, darbepoetin)?
   ☐ Yes. Please list the drug name, dose and frequency, dates/duration of use, and outcomes below.
   Drug name Dose and frequency
   Dates/duration of use ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   ☐ No. Please explain why not.
3. If the member has MDS with ring sideroblasts, has the member had a trial with Reblozyl?
   ☐ Yes. Please list the dose and frequency, dates/duration of use, 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 why not.
4. If the member has MDS associated with a del 5q cytogenic abnormality, has the member had a trial with lenalidomide?
   ☐ Yes. Please list the dose and frequency, dates/duration of use, 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 why not.

Section IX. 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.

over

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.

over

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.)