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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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Multiple Sclerosis 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

- ☐ Bafiertam (monomethyl fumarate)
- ☐ Briumvi (ublituximab-xiiy)
- ☐ dalfampridine > 2 units/day
- ☐ dimethyl fumarate > 2 units/day
- ☐ Extavia (interferon beta-1b)
- ☐ fingolimod capsule > 1 unit/day
- ☐ Kesimpta (ofatumumab prefilled syringe)
- ☐ Lemtrada (alemtuzumab)[MB]
- ☐ Mavenclad (cladribine tablet)
- ☐ Mayzent (siponimod)
- ☐ Ocrevus (ocrelizumab)
- ☐ Plegridy (peginterferon beta-1a)
- ☐ Ponvory (ponesimod)
- ☐ Tascenso ODT (fingolimod orally disintegrating tablet)
- ☐ teriflunomide > 1 unit/day
- ☐ Vumerity (diroximel fumarate)
- ☐ Zeposia (ozanimod)

[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.)

- ☐ Clinically Isolated Syndrome (CIS)
- ☐ Multiple Sclerosis (MS)
  - Subtype ☐ relapsing-remitting (RR) ☐ primary progressive (PP) ☐ non-active secondary progressive (SP)
    ☐ active SP (member has had a relapse in the past two years)
- ☐ Other (Please indicate.)

Is the prescriber a neurologist?

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

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 this member a referral candidate for care coordination? ☐ Yes ☐ No
If yes, MassHealth will offer care coordination services to this member. Please describe which additional behavioral health services would be beneficial. *Please inform the member, parent, or legal guardian to expect outreach from a MassHealth representative of care coordination services.*

Section I. Please complete for requests for Lemtrada.

Has the member had trials with two of the following agents: Briumvi or Ocrevus, dimethyl fumarate or Vumerity, fingolimod capsule, glatiramer, interferon formulations, teriflunomide, or Tysabri?

☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XIII below.*

☐ No. Please describe why the member is not a candidate for these agents.

Section II. Please complete for requests for Ocrevus for CIS, RRMS, and active SPMS.

Has the member had a trial with Briumvi?

☐ Yes. Please list the drug name, dates/duration of use, and outcomes in Section XIII below.*

☐ No. Please describe why the member is not a candidate for Briumvi.

Section III. Please complete for requests for dalfampridine.

Is the medication requested to improve walking distance in a member with multiple sclerosis?

☐ Yes

☐ No. Please describe the clinical rationale for using the requested medication below.

Section IV. Please complete for requests for Mayzent, Ponvory and Zeposia.

1. Please provide medical necessity for use instead of fingolimod capsule.
2. Has the member had a trial with one of the following agents: Briumvi or Ocrevus, dimethyl fumarate or Vumerity, glatiramer, interferon formulations, or teriflunomide?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XIII below.*
   ☐ No. Please describe why the member is not a candidate for these agents.
3. For requests for Mayzent, please indicate CYP2C9 genotype.
   ☐ *1/*1 ☐ *1/*2 ☐ *1/*3 ☐ *2/*2 ☐ *2/*3 ☐ *3/*3 ☐ Other

Section V. Please complete for requests for Kesimpta.

Has the member had trials with two of the following agents: Briumvi or Ocrevus, dimethyl fumarate or Vumerity, fingolimod capsule, glatiramer, interferon formulations, teriflunomide, or Tysabri?

☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XIII below.*

☐ No. Please describe why the member is not a candidate for these agents.

Section VI. Please complete for requests for Extavia.

Please provide medical necessity for use instead of Betaseron (interferon beta-1b).

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Section VII. Please complete for requests for Plegridy.

1. Please provide medical necessity for use instead of interferon beta-1a (Avonex, Rebif).

2. Has the member had a trial with one of the following agents: Briumvi or Ocrevus, dimethyl fumarate or Vumerity, fingolimod capsule, glatiramer, Lemtrada, teriflunomide, or Tysabri?
   ☐ Yes. Please list the drug name, dates/duration of use, and outcomes in Section XIII below.*
   ☐ No. Please describe why the member is not a candidate for these agents.

Section VIII. Please complete for requests for fingolimod capsule.

Please indicate: Member's current weight Date

Section IX. Please complete for requests for Mavenclad.

Has the member had trials with three of the following agents: Briumvi or Ocrevus, dimethyl fumarate or Vumerity, fingolimod capsule or Mayzent, glatiramer, interferon formulations, teriflunomide, or Tysabri?
☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XIII below.*
☐ No. Please describe why the member is not a candidate for these agents.

Section X. Please complete for requests for Bafiertam and Vumerity.

1. Please provide medical necessity for use instead of dimethyl fumarate.

2. For requests for Bafiertam, please provide medical necessity for use instead of Vumerity.

Section XI. Please complete for requests for Tascenso ODT.

1. Please indicate: Member's current weight Date
2. Please provide medical necessity for use instead of fingolimod capsule.

Section XII. Please complete for all requests exceeding quantity limits.

Please describe the medical necessity for using the requested agent above the quantity limit.

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Section XIII. Please complete for all requests as needed.

Please provide the following information regarding previous trials.*

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.

_____

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.

_____

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.

_____

* *Please attach a letter documenting additional trials as necessary*

Section XIV. 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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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.)