



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
<input type="checkbox"/> 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)
<input type="checkbox"/> Fallon Health Online Prior Authorization: go.covermy meds.com/OptumRx Online Prior Authorization: providerportal.surescripts.net/ProviderPortal/optum Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033
<input type="checkbox"/> Health New England Online Prior Authorization: go.covermy meds.com/OptumRx Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545
<input type="checkbox"/> Mass General Brigham Health Plan Online Prior Authorization (Non-Specialty Drugs): go.covermy meds.com/OptumRx Online Prior Authorization (Specialty/Medical Drugs): provider.massgeneralbrighamhealthplan.org Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555
<input type="checkbox"/> Tufts Health Plan Online Prior Authorization: point32health.promptpa.com Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985
<input type="checkbox"/> WellSense Health Plan Online Prior Authorization: wellsense.org/providers/ma/pharmacy/prior-authorizations Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822

Antiretroviral 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

Antiretroviral requested

- | | |
|--|---|
| <input type="checkbox"/> Cimduo (lamivudine/tenofovir disoproxil fumarate) | <input type="checkbox"/> Rukobia (fostemsavir) |
| <input type="checkbox"/> efavirenz/lamivudine/tenofovir disoproxil fumarate (600 mg/300 mg/300 mg) | <input type="checkbox"/> Sunlenca (lenacapavir) |
| <input type="checkbox"/> efavirenz/lamivudine/tenofovir disoproxil fumarate (400 mg/300 mg/300 mg) | <input type="checkbox"/> tenofovir disoproxil fumarate tablet > 1 unit/day |
| <input type="checkbox"/> fosamprenavir | <input type="checkbox"/> Tivicay (dolutegravir) > 1 unit/day |
| <input type="checkbox"/> maraviroc | <input type="checkbox"/> Trogarzo (ibalizumab-uiyk) |
| <input type="checkbox"/> nevirapine extended-release | <input type="checkbox"/> Viread (tenofovir disoproxil fumarate) powder \geq 13 years of age |

Dose, frequency, and duration of medication requested

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

HIV-1 Current viral load and date

pre-exposure prophylaxis (PreEP)

Chronic Hepatitis B

Other (specify)

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 tenofovir disoproxil fumarate tablet > 1 unit/day.

Please describe medical necessity for exceeding the quantity limit.

Section II. Please complete for requests for Viread powder for members \geq 13 years of age.

Please describe medical necessity for use of the requested formulation.

Section III. Please complete for Tivicay requests > 1 unit/day.

1. Will the member be taking the requested medication concurrently with carbamazepine, efavirenz, fosamprenavir/ritonavir, Aptivus (tipranavir)/ritonavir, or rifampin?

Yes. Please document drug name with dose and frequency. No

Drug Dose and Frequency

2. Does the member have integrase strand transfer inhibitor (INSTI)-associated resistance substitutions or clinically suspected INSTI-resistance?

Yes No

Section IV. Please complete for fosamprenavir requests.

1. Has the member tried an antiretroviral regimen containing atazanavir, darunavir, or ritonavir?

Yes. Please describe the outcome. Adverse reaction Inadequate response Other

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

No. Explain why atazanavir, darunavir, and ritonavir are not appropriate for this member.

2. Will the member be taking the requested medication concurrently with at least one other antiretroviral?

Yes. Please document drug name with dose and frequency. No

Drug Dose and Frequency

Section V. Please complete for nevirapine extended-release requests.

Please attach medical records documenting an inadequate response or adverse reaction to nevirapine immediate-release formulation.

Section VI. Please complete for Cimduo and efavirenz/lamivudine/tenofovir disoproxil fumarate requests.

1. Does the member experience any of the following? (Check all that apply.)

Yes

Significant psychiatric diagnosis leading to documented difficulty with adherence.

Please document diagnosis.

Homelessness and difficulty storing larger amounts of medications.

Difficulty with adherence leading to complications.

Developmental issues without adequate support to properly manage their own HIV regimen.

No. Please provide medical necessity for use of the combination product instead of the commercially available separate agents.

2. For members < 18 years of age, please provide member's current weight.

3. For Cimduo, will the member be taking the requested medication concurrently with at least one other antiretroviral?

Yes. Please document drug name with dose and frequency. No

Drug Dose and Frequency

Section VII. Please complete for Rukobia and Sunlenca requests.

1. Is the member antiretroviral-experienced with documented historical or baseline resistance, intolerability, and/or contraindication to antiretroviral?

Yes. Please document drug name and outcome.* No

Drug Intolerability Resistant Other

Briefly describe details of intolerability, resistance, or other.

2. Has the member failed current antiretroviral regimen due to resistance, intolerance, or safety considerations?

Yes. Please document drug name and outcome.* No

Drug Intolerability Resistant Other

Briefly describe details of intolerability, resistance, or other.

3. Will the member be taking the requested medication concurrently with at least one other antiretroviral?

Yes. Please document drug name with dose and frequency. No

Drug Dose and Frequency

Section VIII. Please complete for Trogarzo requests.

1. Does the member have resistance to one agent from each of the three classes of antiretrovirals [nucleoside analog reverse transcriptase inhibitor (NRTI), non-nucleoside reverse transcriptase inhibitor (NNRTI), protease inhibitor (PI)]?

Yes. Please document drug names and outcomes.* No

NRTI Resistant Other

NNRTI Resistant Other

PI Resistant Other

Briefly describe details of resistance or other.

2. Will the member be taking the requested medication concurrently with at least one other antiretroviral?

Yes. Please document drug name with dose and frequency. No

Drug Dose and Frequency

3. Has the member tried Rukobia or Sunlenca?

Yes. Please describe the outcome. Adverse reaction Inadequate response Other

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

No. Explain why Rukobia and Sunlenca are not appropriate for this member.

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.

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.

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.)