



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.covermymeds.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.covermymeds.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.covermymeds.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

Asthma/Allergy Monoclonal Antibodies

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Cinqair (reslizumab) ^{MB} | <input type="checkbox"/> Dupixent (dupilumab) | <input type="checkbox"/> Fasenra (benralizumab) |
| <input type="checkbox"/> Nemluvio (nemolizumab-ilto) | <input type="checkbox"/> Nucala (mepolizumab) | <input type="checkbox"/> Tezspire (tezepelumab-ekko) |
| <input type="checkbox"/> Xolair (omalizumab) | | |

Dose, frequency, and duration of medication requested

- Naïve to therapy Continuation of therapy

^{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.

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

- | | |
|--|--|
| <input type="checkbox"/> Chronic idiopathic urticaria | <input type="checkbox"/> Moderate-to-severe eosinophilic asthma |
| <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD) | <input type="checkbox"/> Moderate-to-severe atopic dermatitis |
| <input type="checkbox"/> Chronic rhinosinusitis with nasal polyps | <input type="checkbox"/> Oral corticosteroid-dependent asthma |
| <input type="checkbox"/> Eosinophilic granulomatosis with polyangiitis | <input type="checkbox"/> Prurigo nodularis |
| <input type="checkbox"/> Hypereosinophilic syndrome | <input type="checkbox"/> Severe asthma |
| <input type="checkbox"/> IgE-mediated food allergy | <input type="checkbox"/> Other (Please indicate.) <input type="text"/> |
| <input type="checkbox"/> Moderate-to-severe allergy-related asthma | |

Please complete the following for all requests.

1. Member's current weight Date
2. Please indicate prescriber specialty. Allergy & immunology Dermatology Otolaryngology
 Pulmonology Other (Please specify.)
3. Please indicate billing preference. Pharmacy Prescriber in-office Hospital outpatient
If applicable, please also complete section for professionally administered medications at end of form.
4. 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 Xolair for the diagnosis of moderate-to-severe allergy-related asthma, for Cinqair, Fasenra, and Nucala for the diagnosis of severe eosinophilic asthma, and for Tezspire for the diagnosis of severe asthma.

For Xolair, please complete questions 1 through 4. For Cinqair, Fasenra, and Nucala, complete questions 3 and 4. For Tezspire, complete question 4.

1. Pretreatment serum IgE level Test date
Does the member have a history of positive skin test or radioallergosorbent test (RAST) to an aeroallergen(s)?
- Yes. Please list the allergens.
- No
2. For requests for the 150 mg and 300 mg syringe or auto-injection, please provide medical necessity for the requested formulation instead of the vial formulation.
3. Does the member have evidence of an eosinophilic phenotype of asthma?
- Yes. Please explain.
- No
4. Has the member tried other medications to treat this condition [including beta agonists, inhaled and oral corticosteroids, leukotriene modifiers, or combination therapies (LABA/ICS)]?
- Yes. Please list the drug name, dates/duration of trials, and outcomes below.*
- Drug name 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, contraindication, or other.
- Drug name 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, contraindication, or other.
- Drug name 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, contraindication, or other.
- No. Please explain why not.

Section II. Please complete for Xolair requests for the diagnosis of chronic idiopathic urticaria.

1. Has the member tried two different histamine₁ antihistamines?
- Yes. Please list the drug name, dates/duration of trials, and outcomes below.*
- Drug name 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, contraindication, or other.
- Drug name 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, contraindication, or other.

No. Please describe why histamine₁ antihistamines are not appropriate for this member.

2. Has the member tried a histamine₂ antihistamine?

Yes. Please list the drug name, dates/duration of trials, and outcomes below.*

Drug name 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, contraindication, or other.

No. Please describe why histamine₂ antihistamines are not appropriate for this member.

3. For requests for the 150 mg and 300 mg syringe or auto-injection, please provide medical necessity for the requested formulation instead of the vial formulation.

Section III. Please complete for Xolair requests for the diagnosis of IgE-mediated food allergy.

1. Pretreatment serum IgE level Test date

2. Does the member have a history of positive skin test or radioallergosorbent test (RAST) to food allergen(s)?

Yes. Please list the allergens.

No

3. For requests for the 150 mg and 300 mg syringe or auto-injection, please provide medical necessity for the requested formulation instead of the vial formulation.

Section IV. Please complete for Fasenra and Nucala requests for the diagnosis of eosinophilic granulomatosis with polyangiitis.

1. Has the member tried a systemic glucocorticoid?

Yes. Please list the drug name, dates/duration of trials, and outcomes below.*

Drug name 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, contraindication, or other.

No. Please describe why systemic glucocorticoids are not appropriate for this member.

2. For Nucala, has the member tried Fasenra for this condition?

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, contraindication, or other.

- No. Please describe why Fasenra is not appropriate for this member.

Section V. Please complete for Nucala requests for hypereosinophilic syndrome.

1. Has a non-hematologic secondary cause been excluded? Yes No

2. Has the member tried a systemic glucocorticoid?

- Yes. Please list the drug name, dates/duration of trials, and outcomes below.*

Drug name 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, contraindication, or other.

- No. Please describe why systemic glucocorticoids are not appropriate for this member.

3. Has the member tried hydroxyurea, interferon alfa, or methotrexate?

- Yes. Please list the drug name, dates/duration of trials, and outcomes below.*

Drug name 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, contraindication, or other.

- No. Please describe why hydroxyurea, interferon alfa, and methotrexate are not appropriate for this member.

Section VI. Please complete for Dupixent requests for moderate-to-severe atopic dermatitis.

1. Has the member tried a superpotent or potent topical corticosteroid to treat this condition?

- Yes. Please list the drug name, dates/duration of trials, and outcome below.*

Drug name 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, contraindication, or other.

- No. Please describe why a superpotent or potent topical corticosteroid is not appropriate for this member.

2. Has the member tried topical tacrolimus or Eucrisa to treat this condition?

- Yes. Please list the dates/duration of trial and outcome.*

Drug name 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, contraindication, or other.

- No. Please describe why topical tacrolimus and Eucrisa are not appropriate for this member.

Section VII. Please complete for Dupixent requests for moderate-to-severe eosinophilic asthma and oral corticosteroid-dependent asthma.

For requests for oral corticosteroid-dependent asthma, only question 1 is required.

1. Has the member tried other medications to treat this condition (including combination inhaler, combination of an inhaled corticosteroid and a long-acting beta agonist inhaler or chronic oral corticosteroids)?

Yes. Please list the drug names, dates/duration of trials, and outcomes below.*

Drug name 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, contraindication, or other.

Drug name 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, contraindication, or other.

No. Please describe why other medications are not appropriate for this member.

2. Does the member have evidence of an eosinophilic phenotype of asthma?

Yes. Please explain.

No

Section VIII. Please complete for Dupixent requests for COPD.

1. Has the member tried Breztri or Trelegy (*triple inhaled therapy containing a corticosteroid*)?

Yes. Please list the drug names, dates/duration of trials, and outcomes below.*

Drug name 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, contraindication, or other.

Drug name 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, contraindication, or other.

No. Please describe why Breztri and Trelegy (*triple inhaled therapy containing a corticosteroid*) are not appropriate for this member.

2. Has the member tried Anoro, Bevespi, Duaklir, or Stiolto (*dual inhaled therapy*)?

Yes. Please list the drug names, dates/duration of trials, and outcomes below. *

Drug name 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, contraindication, or other.

Drug name 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, contraindication, or other.

No. Please describe why Anoro, Bevespi, Duaklir, and Stiolto (*dual inhaled therapy*) are not appropriate for this member.

3. Does the member have evidence of an eosinophilic phenotype?

Yes. Please explain.

No

4. Will the requested agent be used as adjunctive therapy with either dual or triple inhaled therapy?

Yes

No. Please describe why not.

Section IX. Please complete for Dupixent, Nucala, and Xolair requests for nasal polyps.

1. Has the member tried an oral corticosteroid to treat this condition?

Yes. Please list the drug name, dates/duration of trials, and outcome below.*

Drug name 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, contraindication, or other.

No. Please describe why oral corticosteroids are not appropriate for this member.

2. Has the member tried an intranasal corticosteroid to treat this condition?

Yes. Please list the drug name, dates/duration of trials, and outcome below.*

Drug name 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, contraindication, or other.

No. Please describe why intranasal corticosteroids are not appropriate for this member.

3. For requests for Dupixent, has the member failed a prior nasal surgery? Yes No

4. Will the requested agent be used as adjunctive therapy?

Yes

No. Please describe why not.

5. For requests for Xolair 150 mg and 300 mg syringe or auto-injection, please provide medical necessity for the requested formulation instead of the vial formulation.

Section X. Please complete for Dupixent requests for eosinophilic esophagitis.

1. Has the member tried a proton pump inhibitor to treat this condition?

Yes. Please list the drug name, dates/duration of trials, and outcome below.*

Drug name 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, contraindication, or other.

- No. Please describe why proton pump inhibitors are not appropriate for this member.

2. Has the member tried budesonide or fluticasone propionate to treat this condition?

- Yes. Please list the drug name, dates/duration of trials, and outcome below.*

Drug name

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, contraindication, or other.

- No. Please describe why budesonide and fluticasone propionate are not appropriate for this member.

Section XI. Please complete for Dupixent and Nemluvio requests for prurigo nodularis.

1. Has the member tried a superpotent or potent topical corticosteroid to treat this condition?

- Yes. Please list the drug name, dates/duration of trials, and outcome below.*

Drug name

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, contraindication, or other.

- No. Please describe why a superpotent or potent topical corticosteroid is not appropriate for this member.

2. Has the member tried an intralesional corticosteroid to treat this condition?

- Yes. Please list the drug name, dates/duration of trials, and outcome below.*

Drug name

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, contraindication, or other.

- No. Please describe why intralesional corticosteroids are not appropriate for this member.

3. Has the member tried phototherapy to treat this condition?

- Yes. Please list the drug name, dates/duration of trials, and outcome below.*

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, contraindication, or other.

- No. Please describe why phototherapy is not appropriate for this member.

4. For Nemluvio, has the member tried Dupixent to treat this condition?

- Yes. Please list the dose and frequency, dates/durations 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, contraindication, or other.

No. Please describe why Dupixent is not appropriate for this member.

* Please attach a letter documenting additional trials as necessary.

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.

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.)