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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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Cystic Fibrosis 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 (Where applicable, the brand name is provided in brackets for reference.)

- ☐ Alyftrek (vanzacaftor/tezacaftor/deutivacaftor)
- ☐ Bronchitol (mannitol inhalation powder)
- ☐ Kalydeco (ivacaftor)
- ☐ Orkambi (lumacaftor/ivacaftor)
- ☐ Symdeko (tezacaftor/ivacaftor)
- ☐ Tobi Podhaler (tobramycin inhalation powder)
- ☐ tobramycin inhalation solution [Bethkis]
- ☐ tobramycin inhalation solution [Kitabis Pak]
- ☐ Trikafta (elexacaftor/tezacaftor/ivacaftor)

Dose, frequency, and duration of medication requested

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

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

☐ Cystic Fibrosis [Please specify genetic mutation(s) below.]

Does the member have *Pseudomonas aeruginosa*? ☐ Yes ☐ No

☐ Other

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 initial requests for Alyftrek, Kalydeco, Orkambi, Symdeko, and Trikafta.

1. Please document member's baseline body mass index (BMI). Date
2. For members > 6 years of age, please document member's baseline percent predicted forced expiratory volume in one second (ppFEV1). Date

Section II. Please complete for recertification requests for Kalydeco, Orkambi, Symdeko, and Trikafta.

1. Please document member's current BMI. Date
   Has the member demonstrated an improvement in BMI? ☐ Yes ☐ No
2. For members > 6 years of age, please document member's current ppFEV1.
   Date
   Has the member demonstrated an improvement in lung function? ☐ Yes ☐ No

3. Has the member demonstrated a reduced frequency of clinical exacerbations since initiating the requested medication? ☐ Yes ☐ No

   If yes, please describe.

4. If member has not demonstrated improvement in the ppFEV1, BMI or frequency of clinical exacerbations, please document response to therapy.

Section III. Please complete for Tobi Podhaler and tobramycin inhalation solution (generic Bethkis and Kitabis Pak) requests.

Has the member had a trial with tobramycin inhalation solution (generic Tobi)?

☐ Yes. Please list the dose and frequency, dates/duration of trials, 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.

Section IV. Please complete for Bronchitol requests.

1. Documentation that member has passed the Bronchitol Tolerance Test ☐ Yes ☐ No
2. Has the member had a trial with Pulmozyme?

   ☐ Yes. Please list the dose and frequency, dates/duration of trials, 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.

3. Has the member had a trial with sodium chloride for inhalation?

   ☐ Yes. Please list the dose and frequency, dates/duration of trials, 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.

Section V. Please include any other pertinent information (if needed).

Section VI. 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

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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 healthcare 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.)