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

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Targeted Immunomodulators
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

Anti-TNFs

- ☐ Abrilada (adalimumab-afzb)
- ☐ adalimumab-aacf, unbranded
- ☐ adalimumab-aaty, unbranded
- ☐ adalimumab-adaz, unbranded
- ☐ adalimumab-adbm, unbranded
- ☐ adalimumab-fkjp, unbranded
- ☐ adalimumab-ryvk, unbranded
- ☐ Amjevita (adalimumab-atto)
- ☐ Avsola (infliximab-axxq)
- ☐ Cimzia (certolizumab)
- ☐ Cyltezo (adalimumab-adbm)
- ☐ Enbrel (etanercept)
- ☐ Hadlima (adalimumab-bwwd)
- ☐ Hulio (adalimumab-fkjp)
- ☐ Humira (adalimumab)
- ☐ Hyrimoz (adalimumab-adaz)
- ☐ Idacio (adalimumab-aacf)
- ☐ Inflectra (infliximab-dyyb)
- ☐ infliximab, unbranded
- ☐ Remicade (infliximab)
- ☐ Renflexis (infliximab-abda)
- ☐ Simlandi (adalimumab-ryvk)
- ☐ Simponi (golimumab)
- ☐ Simponi Aria (golimumab for infusion)
- ☐ Yuflyma (adalimumab-aaty)
- ☐ Yusimry (adalimumab-aqvh)
- ☐ Zymfentra (infliximab-dyyb)

Interleukin Antagonists

- ☐ Actemra (tocilizumab auto-injection, prefilled syringe)
- ☐ Actemra (tocilizumab vial) [MB]
- ☐ Adbry (tralokinumab-ldrm)
- ☐ Arcalyst (rilonacept)
- ☐ Bimzelx (bimekizumab-bkzx)
- ☐ Cosentyx (secukinumab auto-injection, prefilled syringe)
- ☐ Cosentyx (secukinumab 125 mg/5 mL vial) [MB]
- ☐ Ebglyss (lebrikizumab-lbkz)
- ☐ Ilaris (canakinumab)
- ☐ Ilumya (tildrakizumab-asmn)
- ☐ Kevzara (sarilumab)
- ☐ Kineret (anakinra)
- ☐ Omvoh (mirikizumab-mrkz)
- ☐ Siliq (brodalumab)
- ☐ Skyrizi (risankizumab-rzaa)
- ☐ Spevigo (spesolimab-sbzo)
- ☐ Stelara (ustekinumab 45 mg/0.5 mL prefilled syringe, 90 mg/mL prefilled syringe, 45 mg/0.5 mL vial)
- ☐ Stelara (ustekinumab 130 mg/26 mL vial) [MB]
- ☐ Taltz (ixekizumab)
- ☐ Tofidence (tocilizumab-bavi) [MB]
- ☐ Tremfya (guselkumab)
- ☐ Tyenne (tocilizumab-aazg auto-injection, prefilled syringe)
- ☐ Tyenne (tocilizumab-aazg vial) [MB]

Oral Janus Kinase Inhibitors

- ☐ Cibinqo (abrocitinib)
- ☐ Litfulo (ritlecitinib)
- ☐ Olumiant (baricitinib)
- ☐ Rinvoq (upadacitinib ER tablet)
- ☐ Rinvoq LQ (upadacitinib oral solution)
- ☐ Xeljanz (tofacitinib)
- ☐ Xeljanz XR (tofacitinib extended-release)

Miscellaneous Agents

- ☐ Entyvio (vedolizumab)
- ☐ Orencia (abatacept auto-injection, prefilled syringe)
- ☐ Orencia (abatacept vial) [MB]
- ☐ Otezla (apremilast)
- ☐ Sotyktu (deucravacitinib)
- ☐ Velsipity (etrasimod)
- ☐ Zeposia (ozanimod)

Dose, frequency, and duration of medication requested

[MB] This drug is available through the healthcare 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 healthcare 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 and criteria, if applicable.

Please complete the following for all requests.

1. Member's current weight
2. 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

3. Is the member stabilized on the requested medication?

☐ Yes. Please provide start date. ☐ No

4. Please indicate prescriber specialty below.

☐ Allergy/Immunology ☐ Dermatology ☐ Gastroenterology ☐ Rheumatology ☐ Other

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

- ☐ Acute graft versus host disease (aGVHD) prophylaxis
- ☐ Adult-onset Still's disease (AOSD)
- ☐ Alopecia areata
- ☐ Ankylosing spondylitis (AS)
- ☐ Atopic dermatitis
- ☐ Crohn's disease
  - ☐ Fistulizing Crohn's disease
- ☐ Cytokine release syndrome
- ☐ Deficiency of interleukin-1 receptor antagonist (DIRA)
- ☐ Enthesitis-related arthritis (ERA)
- ☐ Familial cold autoinflammatory syndrome (FCAS)
- ☐ Familial Mediterranean fever (FMF)
- ☐ Giant cell arteritis (GCA)
- ☐ Generalized Pustular Psoriasis
- ☐ Hidradenitis suppurativa (HS) (Hurley Stage II or III)
- ☐ Hyperimmunoglobulin D syndrome (HIDS)/mevalonate kinase deficiency (MKD)
- ☐ Juvenile idiopathic arthritis (JIA)
  - ☐ Polyarticular ☐ Systemic
- ☐ Muckle-Wells syndrome (MWS)
- ☐ Neonatal-onset multisystem inflammatory disease (NOMID)
- ☐ Non-infectious uveitis
- ☐ Non-radiographic axial spondyloarthritis (nr-AxSpA)
- ☐ Oral ulcers associated with Behcet's disease
- ☐ Plaque psoriasis (PsO)
- ☐ Polymyalgia rheumatica (PMR)
- ☐ Psoriatic arthritis (PsA)
- ☐ Recurrent pericarditis
- ☐ Rheumatoid arthritis (RA)
- ☐ Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)
- ☐ Tumor necrosis factor receptor associated periodic syndrome (TRAPS)
- ☐ Ulcerative colitis (UC)
- ☐ Other

Please specify severity of indication below.

☐ Mild ☐ Mild-moderate ☐ Moderate ☐ Moderate-severe ☐ Severe

Section I. Please complete for all requests, except for a diagnosis of aGVHD prophylaxis, alopecia areata, atopic dermatitis, AOSD, cytokine release syndrome, DIRA, FCAS, FMF, GCA, Generalized Pustular Psoriasis, HIDS/MKD, HS (Hurley Stage II or III), MWS, NOMID, non-infectious uveitis, nr-AxSpA, oral ulcers associated with Behcet's disease, PMR, SSc-ILD, or TRAPS.

Has the member tried traditional or biologic disease-modifying antirheumatic drugs (DMARDs)?‡

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

☐ No. Please explain why not.

‡ *For requests for Cimzia, all infliximab products, and Simponi, please provide clinical rationale for use instead of Enbrel and Humira, if applicable. For requests for Remicade, please provide clinical rationale for use instead of unbranded infliximab.*

For requests for Actemra, please provide clinical rationale for use instead of Tyenne.

For requests for Cimzia vial, please provide clinical rationale for use instead of Cimzia prefilled syringe.

For requests for Inflectra, Remicade, or Renflexis, please provide clinical rationale for use instead of unbranded infliximab and Avsola.

For requests for all infliximab products for a diagnosis of UC, a trial with Humira is not required.

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For requests for all adalimumab products (except Humira), please also complete section XIV.
For requests for Olumiant, Rinvoq, or Rinvoq LQ, please document a trial with Xeljanz or Xeljanz XR, or provide clinical rationale for use of the requested agent instead of both Xeljanz and Xeljanz XR, if applicable.
For requests for Rinvoq LQ, please also provide medical necessity for the oral solution formulation.
For requests for Bimzelx, Cosentyx, Ilumya, Siliq, and Tremfya for diagnosis of PsA and PsO, please document a trial with Stelara, Skyrizi, and Talz, or provide clinical rationale for use of the requested agent instead of Stelara, Skyrizi, and Taltz, if applicable.
For requests for Tremfya for diagnosis of UC, please document a trial with Stelara, Skyrizi, and Omvoh, or provide clinical rationale for use of the requested agent instead of Stelara, Skyrizi, and Omvoh, if applicable.
For requests for Kevzara for a diagnosis of polyarticular JIA, please document a trial with Enbrel or Humira, or provide clinical rationale for use of the requested agent instead of both Enbrel and Humira
For requests for Stelara and Taltz for a diagnosis of PsA, a trial with a traditional or biologic DMARD is not required.
For requests for Stelara for a diagnosis of UC, a trial with a traditional or biologic DMARD is not required.

Section II. Please also complete for treatment of PsO with any adalimumab product, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Ilumya, Inflectra, Otezla, Remicade, Renflexis, Siliq, Skyrizi, Stelara, Taltz, Tremfya, or unbranded infliximab.

Has the member tried other therapies to treat this condition including topical agents, systemic agents, and phototherapy?

☐ Yes. Please list the names of the therapies, dates/duration of trials, and outcomes in Section XIX below.*

☐ No. Please explain why not.

Section III. Please also complete for treatment of AS with anti-TNFs, Bimzelx, Cosentyx, Rinvoq, Taltz, Xeljanz, and Xeljanz XR, and for treatment of nr-AxSpA with Bimzelx, Cimzia, Cosentyx, Rinvoq, and Taltz.

1. Has the member tried two nonsteroidal anti-inflammatory drugs (NSAIDs)?
   ☐ Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XIX below.*
   ☐ No. Please explain why not.
2. If the request is for Bimzelx, Cosentyx, Rinvoq, Xeljanz, or Xeljanz XR for the treatment of AS, has the member tried one anti-TNF agent that is FDA-approved for AS?
   ☐ Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XIX below.*
   ☐ No. Please explain why not.
3. If the request is for Bimzelx, Cosentyx, or Rinvoq for the treatment of AS, has the member tried Taltz?
   ☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XIX below.*
   ☐ No. Please explain why not.
4. If the request is for Bimzelx, Cosentyx or Rinvoq for the treatment of nr-AxSpA, has the member tried one anti-TNF agent?
   ☐ Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XIX below.*
   ☐ No. Please explain why not.
5. If the request is for Bimzelx, Cosentyx or Rinvoq for the treatment of nr-AxSpA, has the member tried Taltz?
   ☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XIX below.*
   ☐ No. Please explain why not.

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Section IV. Please complete for treatment of cytokine release syndrome with Actemra IV, Tofidence, and Tyenne.

Please provide anticipated date of administration with concurrent CAR T-cell therapy.

Section V. Please complete for treatment of non-infectious uveitis with Humira and adalimumab products and for treatment of GCA with Actemra, Tofidence, and Tyenne.

1. Has the member tried other medications to treat this condition including glucocorticoid therapy for Actemra, Tofidence, and Tyenne or glucocorticoid and immunosuppressive therapy for Humira and adalimumab products?

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

☐ No. Please explain why not.

2. For Actemra, please provide clinical rationale for use of requested agent instead of Tyenne.
3. For requests for all adalimumab products (except Humira), please also complete section XIV.

Section VI. Please complete for treatment of SSc-ILD with Actemra SC and Tyenne SC.

1. Has the member tried cyclophosphamide or mycophenolate?

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

☐ No. Please explain why not.

2. For Actemra, please provide clinical rationale for use of requested agent instead of Tyenne.

Section VII. Please complete for treatment of DIRA with Arcalyst and Kineret.

1. Has the diagnosis been confirmed through genetic testing? ☐ Yes. ☐ No.
2. If the request is for Arcalyst, has the member tried Kineret?

☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XIX below.*

☐ No. Please explain why not.

Section VIII. Please complete for treatment FCAS and MWS with Arcalyst and Ilaris and for treatment of FMF, HIDS/MKD, and TRAPS with Ilaris.

1. Has the diagnosis been confirmed through genetic testing? ☐ Yes. ☐ No.
   If no, does the member have evidence of symptoms indicative of the disease?

   ☐ Yes. Please explain. ☐ No
2. If the request is for treatment of FCAS and MWS with Arcalyst, has the member tried Ilaris?

   ☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XIX below.*

   ☐ No. Please explain why not.
3. If the request is for treatment of FMF with Ilaris, has the member tried colchicine?

   ☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XIX below.*

   ☐ No. Please explain why not.

Section IX. Please complete for treatment of AOSD and systemic JIA with Ilaris, and for treatment of recurrent pericarditis with Arcalyst.

1. Has the member tried other medications to treat this condition, including corticosteroids and Kineret?

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

☐ No. Please explain why not.

2. If the request is for treatment of recurrent pericarditis with Arcalyst, has the member tried colchicine and NSAIDs or aspirin?

☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XIX below.*

☐ No. Please explain why not.

Section X. Please complete for aGVHD prophylaxis with Orencia.

1. Will the requested agent be used in combination with a calcineurin inhibitor?

☐ Yes. Please list drug name, dose, and frequency below.

Drug name Dose and frequency

☐ No. Please explain why not.

2. Will the requested agent be used in combination with methotrexate?

☐ Yes. Please list dose and frequency.

☐ No. Please explain why not.

Section XI. Please complete for treatment of atopic dermatitis with Adbry, Cibinqo, Ebglyss, and Rinvoq.

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

☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XIX below.*

☐ No. Please explain why not.

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

☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XIX below.*

☐ No. Please explain why not.

3. For Adbry and Ebglyss, has the member tried other medications to treat this condition, including a systemic immunomodulatory agent?

☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XIX below.*

☐ No. Please explain why not.

4. For Cibinqo and Rinvoq, has the member tried Dupixent to treat this condition?

☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XIX below.*

☐ No. Please explain why not.

Section XII. Please complete for treatment of alopecia areata with Litfulo and Olumiant.

Has the member tried other medications to treat this condition, including a topical corticosteroid, an intralesional corticosteroid, and Xeljanz or Xeljanz XR?

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

☐ No. Please explain why not.

Section XIII. Please complete for treatment of polymyalgia rheumatica with Kevzara.

1. Has the member tried a systemic corticosteroid to treat this condition?

☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XIX below.*

☐ No. Please explain why not.

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2. Has the member tried methotrexate to treat this condition?

☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XIX below.*

☐ No. Please explain why not.

Section XIV. Please also complete for Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry, and unbranded adalimumab generic requests.

Has the member had a trial with Humira?

☐ Yes. Please attach medical records documenting an inadequate response or adverse reaction to Humira.

☐ No. Please document clinical rationale for use of the requested agent instead of Humira.

Section XV. Please also complete for Velsipity and Zeposia.

Has the member had a trial with Entyvio?

☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XIX below.*

☐ No. Please explain why not.

Section XVI. Please also complete for Spevigo.

1. Member's current weight Date
2. For Spevigo prefilled syringe, has the member tried a biologic DMARD?
   ☐ Yes. Please list the drug names, dates/duration of trials, and outcomes in Section XIX below.
   ☐ No. Please explain why not.
3. For Spevigo prefilled syringe, has the member had a positive response to treatment for an acute pustular psoriasis flare using Spevigo vial? ☐ Yes ☐ No

Section XVII. Please also complete for Zymfentra.

1. Please document the medical necessity for the subcutaneous formulation instead of an intravenous infliximab formulation.
2. Is the member currently stable on an infliximab product?
   ☐ Yes. Please provide start date.
   ☐ No. Please explain why not.

Section XVIII. Please complete for treatment of HS with Bimzelx and Cosentyx.

1. For Bimzelx, has the member had a trial with Humira and Cosentyx?
   ☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XIX below.*
   ☐ No. Please explain why not.
2. For Cosentyx, has the member had a trial with Humira?
   ☐ Yes. Please list the drug name, dates/duration of trial, and outcome in Section XIX below.*
   ☐ No. Please explain why not.

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Section XIX . Please complete for all requests as needed.

Please provide the following information regarding previous trials.*

Drug name/Therapy ______ 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/Therapy ______ 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/Therapy ______ 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/Therapy ______ 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/Therapy ______ 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 XX. Please complete for requests for quantities above quantity limits.

Please describe the clinical rationale for exceeding the quantity limit.

______

______

Section XXI. 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.

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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.)