



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

Antiemetics

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"/> Akynzeo (fosnetupitant/palonosetron injection) > 2 units/28 days | <input type="checkbox"/> Emend (aprepitant 125 mg powder for oral suspension) > 6 units/28 days |
| <input type="checkbox"/> Akynzeo (netupitant/palonosetron capsule) > 2 units/28 days | <input type="checkbox"/> Focinvez (fosaprepitant injection) |
| <input type="checkbox"/> Anzemet (dolasetron) | <input type="checkbox"/> fosaprepitant injection > 2 units/28 day |
| <input type="checkbox"/> aprepitant 40 mg, 125 mg capsule > 2 units/28 days | <input type="checkbox"/> granisetron tablet > 2 units/28 days |
| <input type="checkbox"/> aprepitant 80 mg > 4 units/28 days | <input type="checkbox"/> ondansetron 16 mg orally disintegrating tablet |
| <input type="checkbox"/> aprepitant trifold pack > 2 packs/28 days | <input type="checkbox"/> ondansetron solution ≥ 13 years |
| <input type="checkbox"/> Bonjesta (doxylamine/pyridoxine extended-release) | <input type="checkbox"/> palonosetron 0.25 mg/2 mL injection > 2 units/28 days |
| <input type="checkbox"/> Cinvanti (aprepitant injectable emulsion) | <input type="checkbox"/> palonosetron 0.25 mg/5 mL injection > 2 units/28 days |
| <input type="checkbox"/> doxylamine/pyridoxine delayed-release | <input type="checkbox"/> Sancuso (granisetron transdermal system) |
| | <input type="checkbox"/> Sustol (granisetron extended-release injection) > 2 units/28 days |

Dose, frequency and duration of requested medication

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

- | | |
|--|---|
| <input type="checkbox"/> Chemotherapy-induced nausea and vomiting (CINV) | <input type="checkbox"/> Postoperative nausea and vomiting (PONV) |
| <input type="checkbox"/> Hyperemesis gravidarum | <input type="checkbox"/> Radiation-induced nausea and vomiting (RINV) |
| | <input type="checkbox"/> Other <input type="text"/> |

Section I. Please complete for Cinvanti requests.

Has the member had a trial of oral aprepitant or fosaprepitant injection?

- Yes. Please list the dates/duration of trial and outcomes 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 explain why.

Section II. Please complete for Akynzeo, aprepitant, fosaprepitant injection, palonosetron, and Sustol requests exceeding the quantity limit.

Please describe the medical necessity for exceeding the quantity limit.

Section III. Please complete for ondansetron solution requests.

Does the member have a medical condition in which they are unable to swallow tablets/capsules?

Yes. Please list reason.

No. Please provide clinical rationale why conventional dosage forms cannot be used.

Section IV. Please complete for Sancuso requests.

Has the member had a trial of ondansetron ODT?

Yes. Please list the dates/duration of trial and outcomes 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 explain why.

Section V. Please complete for Bonjesta and doxylamine/pyridoxine delayed-release requests.

1. Has the member had a trial of pyridoxine?

Yes. Please list the dates/duration of trial and outcomes 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 explain why.

2. Has the member had a trial of doxylamine?

Yes. Please list the dates/duration of trial and outcomes 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 explain why.

3. For Bonjesta requests, has the member had a trial of doxylamine/pyridoxine delayed-release?

Yes. Please list the dates/duration of trial and outcomes 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 explain why.

Section VI. Please complete for Anzemet requests.

1. Has the member had a trial of granisetron tablet?

Yes. Please list the dates/duration of trial and outcomes 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 explain why.

2. Has the member had a trial of ondansetron tablet or ondansetron ODT?

Yes. Please list the dates/duration of trial and outcomes 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 explain why.

Section VII. Please complete for Focinvez requests.

Please describe the clinical rationale for use of the requested agent instead of fosaprepitant injection (Emend).

Section VIII. Please complete for ondansetron 16 mg ODT requests.

Please describe the clinical rationale for use of the requested agent instead of ondansetron ODT at an equivalent dose that is available without prior authorization.

Section IX. Please complete for granisetron tablet requests exceeding the quantity limit.

1. Please describe the medical necessity for exceeding the quantity limit.

2. Has the member had a trial of ondansetron oral tablets or ondansetron ODT?

Yes. Please list the dates/duration of trial and outcomes 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 explain why.

3. Is the member on an anti-cancer treatment regimen that includes an oral agent? Yes No

4. Does the member require additional breakthrough treatment for CINV and is already on an antiemetic agent from a different therapeutic class? Yes No

If yes, please list the additional antiemetic agent below.

Section X. 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 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.

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"/>
----------------------	------	----------------------

(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.)