



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 |

Osteoporosis Agents and Calcium Regulators

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

Bisphosphonates

- | | |
|---|---|
| <input type="checkbox"/> alendronate solution | <input type="checkbox"/> ibandronate IV ^{MB} |
| <input type="checkbox"/> Binosto (alendronate effervescent tablet) | <input type="checkbox"/> risedronate |
| <input type="checkbox"/> Fosamax Plus D (alendronate/cholecalciferol) | <input type="checkbox"/> risedronate delayed-release |

Miscellaneous Agents

- | | |
|---|--|
| <input type="checkbox"/> calcitonin salmon injection | <input type="checkbox"/> teriparatide 600 mcg/2.4 mL |
| <input type="checkbox"/> Evenity (romosozumab-aqqg) | <input type="checkbox"/> Tymlos (abaloparatide) |
| <input type="checkbox"/> Duavee (conjugated estrogens/bazedoxifene) | <input type="checkbox"/> Xgeva (denosumab) |
| <input type="checkbox"/> Prolia (denosumab) | <input type="checkbox"/> Yorvipath (palopegteriparatide) |
| <input type="checkbox"/> teriparatide 620 mcg/2.48 mL | |

Dose, frequency, and duration of medication requested

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

- | | |
|--|---|
| <input type="checkbox"/> Giant cell tumor of the bone (Xgeva) (Section VIII) | <input type="checkbox"/> Prevention of bone loss in women receiving aromatase inhibitors for breast cancer |
| <input type="checkbox"/> Glucocorticoid-Induced Osteoporosis (GIO) (Section II) | <input type="checkbox"/> Prevention of skeletal-related events secondary to bone metastases in cancer related to solid tumors (Xgeva) (Section VII) |
| <input type="checkbox"/> Hypercalcemia | <input type="checkbox"/> Prevention of skeletal-related events secondary to multiple myeloma (Xgeva) (Section VII) |
| <input type="checkbox"/> Hypercalcemia of malignancy (Xgeva) (Section VII) | <input type="checkbox"/> Primary/Hypogonadal Osteoporosis |
| <input type="checkbox"/> Hypocalcemia with hypoparathyroidism | <input type="checkbox"/> Treatment of moderate-severe vasomotor symptoms associated with menopause |
| <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Other <input type="text"/> |
| <input type="checkbox"/> Paget's Disease | |
| <input type="checkbox"/> Postmenopausal Osteoporosis (PMO) | |
| <input type="checkbox"/> Prevention of postmenopausal osteoporosis | |
| <input type="checkbox"/> Prevention of bone loss in men receiving androgen deprivation therapy for prostate cancer | |

^{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 status and criteria, if applicable.

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

Section I. Please complete for bisphosphonates, calcitonin salmon injection, Evenity, Prolia, teriparatide 600 mcg/2.4 mL, and teriparatide 620 mcg/2.48 mL as indicated above.

For calcitonin salmon injection requests for the diagnosis of Paget's disease, please complete questions 4 and 5. For calcitonin salmon injection requests for the diagnosis of hypercalcemia, please complete question 7.

1. Please provide results of bone mineral density (BMD) measurements (T-scores of total hip and lumbar vertebrae).

2. Has the member had a radiographically confirmed fracture?

Yes. Please provide site and date below.

Site

Date

No

3. Please list all non-modifiable risk factors for fracture in this member.

4. Has the member tried an oral bisphosphonate and experienced an adverse reaction or inadequate response?

Yes. Please list the dates/duration of oral bisphosphonate trial and outcomes in Section X below.*

No. Please document if there is a contraindication to oral bisphosphonates.

5. If the request is for calcitonin salmon injection, Evenity, teriparatide 600 mcg/2.4 mL, teriparatide 620 mcg/2.48 mL, or Tymlos, has the member tried Prolia, if applicable, or an intravenous bisphosphonate and experienced an adverse reaction or inadequate response?

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

No. Please document if there is a contraindication to Prolia and intravenous bisphosphonates.

6. If the request is for calcitonin salmon injection, Evenity, or Tymlos, has the member tried teriparatide 600 mcg/2.4 mL and experienced an adverse reaction or inadequate response?

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

No. Please document if there is a contraindication to teriparatide 600 mcg/2.4 mL.

7. If the request is for calcitonin salmon injection, has the member tried calcitonin nasal spray and experienced an adverse reaction or inadequate response?

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

No. Please document if there is a contraindication to Prolia and intravenous bisphosphonates.

Section II. Please complete for all agents being requested for the treatment or prevention of Glucocorticoid-Induced Osteoporosis (GIO).

Please provide specifics of the member's chronic glucocorticoid use.

Drug

Dose and Frequency

Dates/Duration

Section III. Please complete for Yorvipath requests.

1. Please indicate prescriber specialty below.

Endocrinologist Nephrologist Surgeon Other

If prescriber is not a specialist, please attach consult notes from specialist.

2. Has the member had a trial with calcium in conjunction with active vitamin D (e.g., calcitriol) supplementation?

Yes. Please list the dates/duration of menopausal hormonal agent trial and outcomes in Section X below.*

No. Please document if there is a contraindication to calcium and active vitamin D supplements.

3. Has the member tried teriparatide 600 mcg/2.4 mL and experienced an adverse reaction or inadequate response?

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

No. Please document if there is a contraindication to teriparatide 600 mcg/2.4 mL.

Section IV. Please complete for teriparatide 620 mcg/2.48 mL requests.

Please provide medical necessity for the use of teriparatide 620 mcg/2.48 mL instead of teriparatide 600

mcg/2.4 mL.

Section V. Please complete for Fosamax Plus D requests.

Please provide medical necessity for the combination product instead of the individual agents.

Section VI. Please complete for Xgeva requests for a diagnosis of prevention of skeletal-related events secondary to bone metastases in cancer related to solid tumors, prevention of skeletal-related events secondary to multiple myeloma, and hypercalcemia of malignancy.

Please indicate prescriber specialty below.

Hematology Oncology Orthopedic Specialist Other

If prescriber is not a specialist, please attach consult notes from specialist.

Section VII. Please complete for Xgeva requests for a diagnosis of giant cell tumor of the bone.

Please describe surgical history and/or prognosis. If surgery is not appropriate for this member, please explain.

Section VIII. Please complete for alendronate solution and Binosto 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 IX. Please complete for Duavee requests.

For the diagnosis of moderate- severe vasomotor symptoms associated with menopause, please complete question 1. For indication of prevention of postmenopausal osteoporosis, please complete questions 1 – 3.

1. Has the member had a trial with one menopausal hormonal agent available without prior authorization?

Yes. Please list the dates/duration of menopausal hormonal agent trial and outcomes in Section X below.*

No. Please document if there is a contraindication to menopausal hormonal agents.

2. Has the member tried an oral bisphosphonate and experienced an adverse reaction or inadequate response?

Yes. Please list the dates/duration of oral bisphosphonate trial and outcomes in Section X below.*

No. Please document if there is a contraindication to oral bisphosphonates.

3. Has the member had a trial with raloxifene and zoledronic acid 5 mg?

Yes. Please list the dates/duration of trials and outcomes in Section X below.*

No. Please explain if there is a contraindication to these trials.

Section X. 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.

* Please attach a letter documenting additional trials as necessary.

Section XI. 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.)