



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
 P.O. Box 2586, Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

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.

Member information

Last name _____ First name _____ MI _____
 MassHealth member ID # _____ Date of birth _____
 Gender (Check one.) F M Member's place of residence home nursing facility

Medication information

Medication requested

Cinqair (reslizumab) Fasentra (benralizumab) Nucala (mepolizumab) Xolair (omalizumab)

Dose, frequency, and duration of medication requested _____

Naïve to therapy Continuation of therapy

Indications

Chronic idiopathic urticaria (Section II) Moderate to severe allergic asthma (Section I)
 Eosinophilic granulomatosis with polyangiitis (Section III) Severe eosinophilic asthma (Section I)
 Other (Please indicate.) _____

Please complete the following for all requests.

1. Please indicate: Member's current weight _____ Date _____
2. Please indicate prescriber specialty. Allergy & immunology Pulmonology
 Other (Please specify.) _____
3. Please indicate whether the request is for pharmacy or in-office billing.
 Pharmacy billing In-office billing

Section I. Please complete questions 1 and 3 for Xolair requests for the diagnosis of moderate to severe allergic asthma. Please complete questions 2 and 3 for Cinqair, Fasentra, and Nucala requests for the diagnosis of severe eosinophilic asthma.

1. For Xolair requests, please provide the following.
 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 Cinqair, Fasentra, and Nucala requests, does the member have evidence of an eosinophilic phenotype of asthma?
 Yes. Please explain. _____
 No.

3. Has 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. _____

** Please attach a letter documenting additional trials as necessary.*

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

1. Has the member had a trial with 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 had a trial with a leukotriene antagonist?

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 leukotriene antagonists are not appropriate for this member.

3. Has the member had a trial with 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.

4. For members naive to Xolair therapy, is the requested starting dose ≤ 150 mg monthly?

Yes.

No. Please provide clinical rationale for initiating therapy at dose > 150mg monthly.

** Please attach a letter documenting additional trials as necessary.*

Section III. Please complete for Nucala requests for the diagnosis of eosinophilic granulomatosis with polyangiitis.

1. Has the member had a trial with 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. Has the member had a trial with azathioprine 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 azathioprine and methotrexate are not appropriate for this member.

** Please attach a letter documenting additional trials as necessary.*

Section IV. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

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.* _____

** Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my 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.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____