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

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**.

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

☐ Bethkis (tobramycin inhalation solution)
☐ Kalydeco (ivacaftor)
☐ Orkambi (lumacaftor/ivacaftor)
☐ Symdeko (tezacaftor/ivacaftor)
☐ Tobi Podhaler (tobramycin inhalation powder)

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.)

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

____

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

☐ Other ____

Section I. Please complete for initial Kalydeco, Orkambi, and Symdeko requests.

1. Please document member's baseline body mass index (BMI). ________________ Date ________
2. Please document member's baseline percent predicted forced expiratory volume in one second (ppFEV1).
   ____ Date ________

Section II. Please complete for requests for continuation of therapy with Kalydeco, Orkambi, or Symdeko.

1. Please document member's current BMI. ______________________ Date ________
   Has the member demonstrated an improvement in BMI? ☐ Yes. ☐ No.
2. 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 Bethkis and Tobi Podhaler requests.

1. Has the member had a trial with tobramycin inhalation solution?

   ☐ 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. ____

2. For Tobi Podhaler, is there medical necessity for the use of the Podhaler formulation?

   ☐ Yes. Please describe. ____ ☐ No.

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

____

____

Section V. 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 ____________________