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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

Inhaled Respiratory 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 (Check one or all that apply.)

Anticholinergics

- ☐ Incruse (umeclidinium) > one inhaler/month
- ☐ Lonhala (glycopyrrolate)
- ☐ Seebri (glycopyrrolate) > one inhaler/month
- ☐ Spiriva Handihaler (tiotropium) > 30 units/month
- ☐ Spiriva Respimat (tiotropium) > one inhaler/month
- ☐ Tudorza (aclidinium) > one inhaler/month

Combination Products

- ☐ Advair (fluticasone/salmeterol)
- ☐ Airduo (fluticasone/salmeterol)
- ☐ Anoro (umeclidinium/vilanterol)
- ☐ Bevespi (glycopyrrolate/formoterol)
- ☐ Breo (fluticasone/vilanterol)
- ☐ Dulera (mometasone/formoterol)
- ☐ Stiolto (tiotropium/olodaterol)
- ☐ Symbicort (budesonide/formoterol)
- ☐ Trelegy (fluticasone furoate/umeclidinium/vilanterol)
- ☐ Utibron (indacaterol/glycopyrrolate)

Corticosteroids

- ☐ Aerospan (flunisolide)
- ☐ Armonair (fluticasone propionate)
- ☐ Arnuity (fluticasone furoate)
- ☐ Asmanex (mometasone) 110 mcg ≥ 12 years
- ☐ Asmanex (mometasone) 220 mcg < 12 years
- ☐ Qvar Redihaler (beclomethasone MDI, breath-actuated)

Long-acting Beta Agonists

- ☐ Arcapta (indacaterol)
- ☐ Brovana (arformoterol)
- ☐ Foradil (formoterol)
- ☐ Perforomist (formoterol)
- ☐ Serevent (salmeterol)
- ☐ Striverdi (olodaterol)

Short-acting Beta Agonists

☐ levalbuterol ☐ Proventil (albuterol)

☐ Proair Respiclick (albuterol) ☐ Ventolin (albuterol)

Dose and frequency of medication requested _____ **Number of inhalers per month** _____

Indication

☐ Asthma (Specify severity below.)

☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

☐ Chronic Obstructive Pulmonary Disease (Specify severity and subtype below.)

Severity ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

Subtype ☐ Chronic bronchitis ☐ Emphysema

☐ Exercise-induced Bronchospasm

☐ Reactive airway disease

☐ Other _____

Please list all other medications currently prescribed for the member for this indication.

_____

_____

Section I. Please complete for levalbuterol, Proair Respiclick, Proventil, and Ventolin requests.

1. For levalbuterol inhaler, Proair Respiclick, Proventil, and Ventolin, has the member had a trial with Proair HFA?
   ☐ Yes. Please list the dates/duration of trials, and outcomes in Section XI.
   ☐ No. Please describe the clinical rationale why Proair HFA is not appropriate for this member.
   _____
2. For levalbuterol inhalation solution, has the member had a trial with albuterol solution?
   ☐ Yes. Please list the dates/duration of trials, and outcomes in Section XI.
   ☐ No. Please describe the clinical rationale why albuterol solution is not appropriate for this member.
   _____
3. For levalbuterol inhalation solution, please describe the clinical rationale for a nebulized formulation.
   _____

Section II. Please complete for Foradil and Serevent requests for a diagnosis of asthma or exercise-induced bronchospasm.

1. Has the member had a trial with an inhaled corticosteroid within the past 4 months?
   ☐ Yes. Please list the dates/duration of trials, and outcomes in Section XI.
   ☐ No. Please describe clinical rationale why inhaled corticosteroids are not appropriate for this member.
   _____
2. Will the member be taking the requested medication concurrently with an inhaled corticosteroid?
   ☐ Yes. Please document drug name with dose, frequency and dates of use.
   Drug name _____ Dose and Frequency _____ Dates/Duration _____
   ☐ No. Please describe why concurrent therapy is not appropriate for this member.
   _____

Section III. Please complete for Asmanex 110 mcg requests in members ≥ 12 years of age and 220 mcg in members < 12 years of age.

Please describe the clinical rationale for the use of requested Asmanex strength in the requested age group.

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Section IV. Please complete for all Brovana, Lonhala and Perforomist requests.

Please describe the clinical rationale for a nebulized formulation.

_____

Section V. Please complete for Advair, Breo, Dulera, and Symbicort requests for a diagnosis of asthma.

1. Has the member had a trial with an inhaled or oral corticosteroid within the past 4 months?
   - ☐ Yes. Please list the dates/duration of trials, and outcomes in Section XI.
   - ☐ No. Please describe clinical rationale why single-entity inhaled corticosteroids are not appropriate for this member. _____
2. Is the member currently being treated with a combination long-acting beta agonist/inhaled corticosteroid?
   - ☐ Yes. Please list dates/duration of use _____ ☐ No.

Section VI. Please complete for fluticasone/salmeterol (Airduo) requests.

Has the member had a trial with Advair?

☐ Yes. Please list the dates/duration of trials and the outcomes in Section XI.

☐ No. Please describe clinical rationale for use of the requested agent in this member.

_____

Section VII. Please complete for Aerospan, Arnuity, and Qvar Redihaler requests.

Has the member had a trial with an inhaled corticosteroid?

☐ Yes. Please list the dates/duration of trials, and outcomes in Section XI.

☐ No. Please document if there is a contraindication to all other inhaled corticosteroids.

_____

Section VIII. Please complete for Armonair requests.

Has the member had a trial with Flovent?

☐ Yes. Please list the dates/duration of trials, and outcomes in Section XI.

☐ No. Please describe clinical rationale for use of the requested agent in this member.

_____

Section IX. Please complete for Trelegy requests.

Has the member had a trial with Breo and Incruse?

☐ Yes. Please list the dates/duration of trials, and outcomes in Section XI.

☐ No. Please describe clinical rationale for use of the requested agent in this member.

_____

Section X. Please complete for Incruse > one inhaler/month, Seebri > one inhaler/month, Spiriva Handihaler > 30 units/month, Spiriva Respimat > one inhaler/month, and Tudorza > one inhaler/month.

1. Has the member had a trial with the requested agent dosed at standard dosing?
   - ☐ Yes. Please list the dates/duration of trials, and outcomes in Section XI.
   - ☐ No. Please describe medical necessity for the use of an increased dose.

     _____
2. Has the member had a trial with a long-acting beta agonist?
   - ☐ Yes. Please list the dates/duration of trials, and outcomes in Section XI.
   - ☐ No. Please describe the clinical rationale why long-acting beta agonists are not appropriate for this member. _____

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3. Has the member had a trial with an inhaled corticosteroid?
   ☐ Yes. Please list the dates/duration of trials, and outcomes in Section XI.
   ☐ No. Please describe the clinical rationale why inhaled corticosteroids are not appropriate for this member. _____

Section XI. Please complete as instructed in sections above.*

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, 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, 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, or other.

_____

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

Section XII. 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 _____