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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

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) ☐ Dupixent (dupilumab) ☐ Fasenra (benralizumab)
☐ Nucala (mepolizumab) ☐ Xolair (omalizumab)

Dose, frequency, and duration of medication requested _____

☐ Naïve to therapy ☐ Continuation of therapy

Indication (Check all that apply.)

☐ Chronic idiopathic urticaria (Section II)
☐ Eosinophilic granulomatosis with polyangiitis (Section III)
☐ Moderate-to-severe allergic asthma (Section I)
☐ Moderate-to-severe eosinophilic asthma (Section IV)
☐ Moderate-to-severe atopic dermatitis (Section IV)
☐ Oral corticosteroid-dependent asthma (Section IV)
☐ 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 ☐ Dermatology ☐ 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 for Xolair for the diagnosis of moderate-to-severe allergic asthma, and for Cinqair, Fasenra, and Nucala for the diagnosis of severe eosinophilic asthma.

For Xolair, please complete questions 1 and 3. For Cinqair, Fasenra, and Nucala, complete questions 2 and 3.

1. 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. 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 histamine$_1$ 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 histamine$_1$ 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 histamine$_2$ 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.
   _____

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☐ No. Please describe why histamine$_2$ 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 > 150 mg 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 Dupixent requests.

For requests for moderate-to-severe atopic dermatitis, please complete questions 1, 2 and 3. For requests for moderate-to-severe eosinophilic asthma, please complete questions 4, 5 and 6. For requests for oral corticosteroid-dependent asthma, please complete question 4.

1. Has member tried a superpotent or potent topical corticosteroid to treat this condition?
   ☐ Yes. Please list the drug name, dates/duration of trials and outcome 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 a superpotent or potent topical corticosteroid is not appropriate for this member._____
2. Has member tried topical tacrolimus to treat this condition?
   ☐ Yes. Please list the dates/duration of trial and outcome.* 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 topical tacrolimus is not appropriate for this member.

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3. Has member tried a systemic immunosuppressive therapy (e.g. azathioprine, cyclosporine, methotrexate, mycophenolate mofetil, mycophenolic acid) to treat this condition?
   ☐ Yes. Please list the drug name, dates/duration of trials and outcome 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 a systemic immunosuppressive therapy is not appropriate for this member.
   _____
4. Has member tried other medications to treat this condition (including combination inhaler, combination of an inhaled corticosteroid and a long-acting beta agonist inhaler or chronic oral corticosteroids)?
   ☐ Yes. Please list the drug names, 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 other medications are not appropriate for this member.
   _____
5. Does the member have evidence of an eosinophilic phenotype of asthma?
   ☐ Yes. Please explain. _____
   ☐ No.
6. Has member tried Nucala to treat this condition?
   ☐ Yes. Please list the dates/duration of trial and outcome.* 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 Nucala is not appropriate for this member.
   _____

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

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.

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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 _____