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

Print Clear

# Oncology 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.

Please note: Chimeric Antigen Receptor (CAR)-T Immunotherapies and Prostate Cancer Agents have specific PA Request forms that contain information pertinent to these medication classes. For these agents, please see more drug-specific PA forms within the MassHealth Drug List at **www.mass.gov/druglist.**

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

**Drug name** _____

**Dose and frequency** _____

**Indication** _____ **Duration of therapy** _____

Please indicate prescriber specialty below.
☐ Hematology ☐ Oncology ☐ Other _____

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

_____

_____

_____

## Section I. Please complete for all requests.

1. Please indicate billing preference. ☐ Pharmacy ☐ Prescriber in-office ☐ Hospital outpatient
   For hospital outpatient billing, provide department-specific facility NPI _____
2. Drug NDC (if known) or service code _____
3. Please describe the cancer type, histology, and any pertinent mutations as applicable.

   _____

   _____
4. Please describe the stage and severity of disease, including status of metastases as applicable.

   _____

   _____

5. Please list any other prior trials. Please list the drug names, dates/duration of use and outcomes below.*
   Drug _____ Dates/duration _____ ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.

   _____

   Drug _____ Dates/duration _____ ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.

   _____

   Drug _____ Dates/duration _____ ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.

   _____

6. For requests for agents with a preferred alternative, please describe clinical rationale for use of the requested agent instead of the preferred alternative.

   _____

   _____

7. Has the member had persistent or recurring disease following surgery and/or radiation therapy? ☐ Yes ☐ No
8. Is the member a candidate for surgery and/or radiation?
   ☐ Yes ☐ No. Please describe. _____

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

**Section II. Please complete for requests for quantities above quantity limits.**

Please describe the clinical rationale for exceeding the quantity limit, including a detailed treatment plan.

_____

_____

_____

**Section III. Please complete for requests for solution and suspension dosage formulations.**

Please provide medical necessity for the use of the requested dosage formulation.

_____

_____

_____

**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.

_____

_____

_____

over

## 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 _____