



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

- | | |
|---|---|
| <input type="checkbox"/> Bethkis (tobramycin inhalation solution) | <input type="checkbox"/> Symdeko (tezacaftor/ivacaftor) |
| <input type="checkbox"/> Kalydeco (ivacaftor) | <input type="checkbox"/> Tobi Podhaler (tobramycin inhalation powder) |
| <input type="checkbox"/> Orkambi (lumacaftor/ivacaftor) | |

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 recertification requests for 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 _____