



Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
 P.O. Box 2586, Worcester, MA 01613-2586  
**Fax:** (877) 208-7428      **Phone:** (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](http://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)       Fasentra (brenalizumab)  
 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)       Moderate-to-severe atopic dermatitis (Section IV)  
 Eosinophilic granulomatosis with polyangiitis (Section III)       Oral corticosteroid-dependent asthma (Section IV)  
 Moderate-to-severe allergic asthma (Section I)       Severe eosinophilic asthma (Section I)  
 Moderate-to-severe eosinophilic asthma (Section IV)       Other (Please indicate.) \_\_\_\_\_

#### Please complete the following for all requests.

- Member's current weight \_\_\_\_\_ Date \_\_\_\_\_
- Please indicate prescriber specialty.  Allergy & immunology  Dermatology  Pulmonology  
 Other (Please specify.) \_\_\_\_\_
- Please indicate billing preference.  Pharmacy  Prescriber in-office  Hospital outpatient  
 For hospital outpatient billing, provide department-specific facility NPI. \_\_\_\_\_  
 Drug NDC (if known) or service code \_\_\_\_\_

### Section I. Please complete for Xolair for the diagnosis of moderate-to-severe allergic asthma, and for Cinqair, Fasentra, and Nucala for the diagnosis of severe eosinophilic asthma.

For Xolair, please complete questions 1 through 3. For Cinqair, Fasentra, and Nucala, complete questions 3 and 4.

- 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. For requests for the 150 mg syringe, please provide medical necessity for the requested formulation instead of the vial formulation.

3. Does the member have evidence of an eosinophilic phenotype of asthma?

- Yes. Please explain. \_\_\_\_\_  
 No

4. 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.

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## 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<sub>1</sub> 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<sub>1</sub> 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<sub>2</sub> 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.  
 \_\_\_\_\_
- No. Please describe why histamine<sub>2</sub> 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.  
 \_\_\_\_\_
5. For requests for the 150 mg syringe, please provide medical necessity for the requested formulation instead of the vial formulation.  
 \_\_\_\_\_

*\* 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 through 3. For requests for moderate-to-severe eosinophilic asthma, please complete questions 4 through 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.  
 \_\_\_\_\_
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.

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**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*

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**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 \_\_\_\_\_