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

Multiple Sclerosis 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

☐ Aubagio (teriflunomide)
☐ dalfampridine
☐ Extavia (interferon beta-1b)
☐ Gilenya (fingolimod)
☐ Lemtrada (alemtuzumab) ^
☐ Mayzent (siponimod)
☐ Ocrevus (ocrelizumab)
☐ Plegridy (peginterferon beta-1a)
☐ Tecfidera (dimethyl fumarate)

^ *This drug is available through the health care professional who administers the drug. MassHealth does not pay for this drug to be dispensed through a retail pharmacy.*

Dose and frequency of medication requested _____

Indication (Check all that apply.)

☐ Clinically Isolated Syndrome
☐ Multiple Sclerosis
Subtype ☐ relapsing-remitting ☐ primary progressive ☐ non-active secondary progressive
☐ active secondary progressive (member has had a relapse in the past two years)
☐ Other (Please indicate.) _____

Is the prescriber a neurologist?

☐ Yes
☐ No. Please attach consultation notes from a neurologist addressing the use of the requested agent.

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 requests for Lemtrada.

Has the member had trials with two of the following agents: Aubagio, Gilenya, glatiramer, interferon formulations, Ocrevus, Tecfidera, or Tysabri?

☐ Yes. Please list the drug names, dates/duration of use, and outcomes below.*
Drug name _____ Dates/duration of use _____
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response

Briefly describe details of adverse reaction or inadequate response.

_____

Drug name _____ Dates/duration of use _____
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response
Briefly describe details of adverse reaction or inadequate response.

_____

☐ No. Please describe why the member is not a candidate for these agents.

_____

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

Section II. Please complete for requests for dalfampridine.

Is the medication requested to improve walking distance in a member with multiple sclerosis?

☐ Yes
☐ No. Please describe the clinical rationale for using the requested medication below.

_____

Section III. Please complete for requests for Mayzent.

1. Has the member had trials with two of the following agents: Aubagio, Gilenya, glatiramer, interferon formulations, Ocrevus, or Tecfidera?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes below.*
   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response
   Briefly describe details of adverse reaction or inadequate response.

   _____

   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response
   Briefly describe details of adverse reaction or inadequate response.

   _____

   ☐ No. Please describe why the member is not a candidate for these agents.

   _____

2. Please indicate CYP2C9 genotype ☐ *1/*1 ☐ *1/*2 ☐ *1/*3 ☐ *2/*2 ☐ *2/*3 ☐ *3/*3 ☐ Other _____

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

Section IV. Please complete for requests for Extavia.

Please provide medical necessity for use instead of Betaseron (interferon beta-1b).

_____

_____

Section V. Please complete for requests for Plegridy.

1. Please provide medical necessity for use instead of interferon beta-1a (Avonex, Rebif).

   _____

   _____

2. Has the member had a trial with one of the following agents: Aubagio, Gilenya, glatiramer, Lemtrada, Ocrevus, Tecfidera, or Tysabri?
   ☐ Yes. Please list the drug name, dates/duration of use, and outcomes below.*
   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response
   Briefly describe details of adverse reaction or inadequate response.

   _____

over

☐ No. Please describe why the member is not a candidate for these agents.

_____

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

Section VI. Please complete for requests for Gilenya.

Please indicate: Member's current weight _____ Date _____

Section VII. 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 _____