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

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
☐ Chronic rhinosinusitis with nasal polyposis
☐ Eosinophilic granulomatosis with polyangiitis
☐ Moderate-to-severe allergic asthma
☐ Moderate-to-severe eosinophilic asthma
☐ Moderate-to-severe atopic dermatitis
☐ Oral corticosteroid-dependent asthma
☐ Severe eosinophilic asthma
☐ Other (Please indicate.) _____

Please complete the following for all requests.

1. Member's current weight _____ Date _____
2. Please indicate prescriber specialty. ☐ Allergy & immunology ☐ Dermatology ☐ Pulmonology ☐ Other (Please specify.) _____
3. 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, Fasenra, and Nucala for the diagnosis of severe eosinophilic asthma.

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

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. 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 the 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. _____

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 _____

over

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$_2$ 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.

   _____

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

   _____

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.

   _____

Section IV. Please complete for Dupixent requests for moderate-to-severe atopic dermatitis.

1. Has the 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 the 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.

   _____

over

3. Has the member tried a systemic immunomodulatory agent (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 immunomodulatory agent is not appropriate for this member.
   _____

Section V. Please complete for Dupixent requests for moderate-to-severe eosinophilic asthma and oral corticosteroid-dependent asthma.

For requests for oral corticosteroid-dependent asthma, only question 1 is required.

1. Has the 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.
   _____
2. Does the member have evidence of an eosinophilic phenotype of asthma?
   ☐ Yes. Please explain. _____
   ☐ No
3. Has the 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.
   _____

Section VI. Please complete for Dupixent requests for chronic rhinosinusitis with nasal polyposis.

1. Has the member tried an oral 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 oral corticosteroids are not appropriate for this member.
   _____
2. Has the member tried an intranasal corticosteroid to treat this condition?
   ☐ Yes. Please list the drug name, dates/duration of trials and outcome below.*
   Drug name _____ Dates/duration of use _____

over

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 intranasal corticosteroids are not appropriate for this member.

_____

3. Has the member tried a leukotriene antagonist 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 leukotriene antagonists are not appropriate for this member.

   _____

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

   _____

   _____

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

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 _____