



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

Oral Respiratory 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

Leukotrienes

montelukast granules zafirlukast zileuton extended-release Zyflo (zileuton)

Other

Daliresp (roflumilast) Esbriet (pirfenidone) Ofev (nintedanib)

Dose and frequency of medication requested _____

Indication (Check all that apply.)

- | | |
|---|--|
| <input type="checkbox"/> Allergic Rhinitis (montelukast only) | <input type="checkbox"/> Exercise-Induced Bronchospasm |
| <input type="checkbox"/> Asthma (specify severity) | <input type="checkbox"/> Idiopathic Pulmonary Fibrosis |
| <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent | <input type="checkbox"/> Systemic sclerosis-associated interstitial lung disease (SSc-ILD) |
| <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease
(Daliresp only) | |

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

Section I. Please complete for montelukast granule requests.

- Please describe medical necessity for the use of the requested formulation.

- For the diagnosis of allergic rhinitis, has the member had a trial with an intranasal antihistamine or intranasal corticosteroid and two oral second-generation antihistamines (e.g., cetirizine, loratadine)?
 Yes. Please list the drug names, dates/duration of trials, and outcomes below.*

No. Please describe why intranasal antihistamines and corticosteroids, and oral second-generation antihistamines are not appropriate for this member.

3. For the diagnosis of exercise-induced bronchospasm, has the member had a trial with inhaled albuterol and cromolyn?

Yes. Please list the drug names, dates/duration of trials, and outcomes below.*

No. Please describe why inhaled albuterol and cromolyn are not appropriate for this member.

Please provide details for the previous trials.

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, or other.

Drug name _____ Dates/duration of use _____

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Briefly describe details of adverse reaction, inadequate response, 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, or other.

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

Section II. Please complete for Daliresp requests.

1. Has the member had a trial with a long-acting bronchodilator (e.g., long-acting beta-agonist, long-acting anticholinergic) within the past four months?

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, or other.

No. Please describe why long-acting bronchodilators are not appropriate for this member.

2. Has the member had a trial with an inhaled corticosteroid within the past four months?

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, or other.

No. Please describe why inhaled corticosteroids are not appropriate for this member.

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

Section III. Please complete for zileuton extended-release and Zyflo requests.

Has the member had a trial with montelukast or zafirlukast?

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, or other.

No. Please describe why montelukast or zafirlukast are not appropriate for this member.

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

Section IV. Please complete for Ofev requests for a diagnosis of SSc-ILD.

Has the member had a trial with cyclophosphamide or mycophenolate?

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, or other.

No. Please describe why cyclophosphamide and mycophenolate are not appropriate for this member.

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

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 product 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 _____