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

Neuromuscular 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

☐ Exondys 51 (eteplirsen) ☐ Spinraza (nusinersen) ☐ Zolgensma (onasemnogene abeparvovec-xioi)

Dose, frequency, and duration of medication requested _____

Indication (Check all that apply.)

☐ Duchenne muscular dystrophy (DMD) ☐ Spinal muscular atrophy (SMA)

☐ Other _____ Type _____

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 _____

Member's current weight _____ Date _____

Is the member stabilized on the requested medication? ☐ Yes. Please provide start date. _____ ☐ No

Section I. Please complete for Exondys 51 requests.

For initial requests, please complete questions 1 through 7. For recertification requests, please complete questions 1, 6, 8 and 9.

1. Please attach laboratory testing results of a confirmed out-of-frame deletion in the DMD gene that is amenable to exon 51 skipping.
2. Is the prescriber a neuromuscular neurologist? ☐ Yes ☐ No. If no, please attach consultation notes from a neuromuscular neurologist addressing the use of the requested agent.
3. Is the member ambulatory as defined by a current six-minute walk test (6MWT-distance walked in six minutes in meters) of ≥ 200 meters?
   Please note, the test must have been observed or completed by the treating provider, or ordered by the treating provider and completed by a qualified medical practitioner.
   ☐ Yes. Distance _____ meters ☐ No
   Date of performance _____ Treatment at the time of test _____

4. Has the member received a corticosteroid for at least six months prior to use with the requested agent?
   ☐ Yes. Please list the drug name, dose and frequency, and dates of use below.
   Drug name _____ Dose and frequency _____ Dates of use _____
   ☐ No. Please explain. _____
5. Will the member be taking the requested agent concurrently with a corticosteroid?
   ☐ Yes. Please document drug name with dose and frequency below.
   Drug name _____ Dose and frequency _____
   ☐ No. Please explain. _____
6. Please provide dates and measurements and attach medical records of baseline measurements for each of the following five timed function tests: timed 10-meter walk/run, timed floor (supine) to stand, timed four-step descend, timed four-step climb, timed sit to stand. Medical records must include the times in seconds, dates of performances, and treatment at the time of tests. Please note, the test must have been observed or completed by the treating provider, or ordered by the treating provider and completed by a qualified medical practitioner.
   Timed 10-meter walk/run (time in seconds) _____
   Date of performance _____ Treatment at the time of test _____
   Timed floor (supine) to stand (time in seconds) _____
   Date of performance _____ Treatment at the time of test _____
   Timed four-step descend (time in seconds) _____
   Date of performance _____ Treatment at the time of test _____
   Timed four-step climb (time in seconds) _____
   Date of performance _____ Treatment at the time of test _____
   Timed sit to stand (time in seconds) _____
   Date of performance _____ Treatment at the time of test _____
7. Please provide dates and measurements and attach medical records of all previous and current six-minute walk tests (6MWTs). Please note, the current test must have been observed or completed by the treating provider, or ordered by the treating provider and completed by a qualified medical practitioner.
   Baseline 6MWT
   Distance _____ meters
   Date of performance _____ Treatment at the time of test _____
   Current 6MWT
   Distance _____ meters
   Date of performance _____ Treatment at the time of test _____
   Additional 6MWT(s)
   Date(s) of performance _____
8. Please provide dates and measurements and attach medical records of current measurements for each of the following five timed function tests: timed 10-meter walk/run, timed floor (supine) to stand, timed four-step descend, timed four-step climb, timed sit to stand. Medical records must include the times in seconds, dates of performances, and treatment at the time of tests. Please note, the test must have been observed or completed by the treating provider, or ordered by the treating provider and completed by a qualified medical practitioner.
   Timed 10-meter walk/run (time in seconds) _____
   Date of performance _____ Treatment at the time of test _____
   Timed floor (supine) to stand (time in seconds) _____
   Date of performance _____ Treatment at the time of test _____
   Timed four-step descend (time in seconds) _____
   Date of performance _____ Treatment at the time of test _____
   Timed four-step climb (time in seconds) _____
   Date of performance _____ Treatment at the time of test _____
   Timed sit to stand (time in seconds) _____
   Date of performance _____ Treatment at the time of test _____

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Section II. Please complete for Spinraza requests.

1. Please attach a copy of genetic test confirming diagnosis of SMA.
2. Is the prescriber a neurologist? ☐ Yes ☐ No. If no, please attach consultation notes from a neurologist addressing the use of the requested agent.
3. Please attach documentation of baseline motor function test.
4. For recertification requests, please attach medical records documenting positive response to therapy (e.g., follow up information on motor function tests and/or member's improvement or stability of function).

Section III. Please complete for Zolgensma requests.

Please note, questions 6 and 7 will not impact the outcome of review for approval of Zolgensma.

1. Please attach a copy of the genetic test confirming diagnosis of SMA and number of copies of SMN2 gene.
2. Is the prescriber a neuromuscular specialist? ☐ Yes ☐ No. If no, please attach the consultation notes from a neuromuscular specialist addressing the use of the requested agent.
3. Please attach a copy of baseline AAV9 antibody test.
4. Does the member have evidence of complete paralysis of limbs? ☐ Yes ☐ No
5. Does the member have evidence of permanent ventilator dependence at the time Zolgensma is to be administered, defined as any of the following?
   Member has an endotracheal tube ☐ Yes ☐ No
   Member has a tracheotomy tube ☐ Yes ☐ No
   Member has at least 14 days of continuous respiratory assistance for at least 16 hours per day ☐ Yes ☐ No
6. Has the member had a trial with Spinraza?
   ☐ Yes. Please list the dose and frequency, dates of use, outcome, and treatment plan below.
   Dose and frequency _____ Dates of use _____
   Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   Will the member continue Spinraza after Zolgensma? ☐ Yes ☐ No
   ☐ No
7. Please describe the functional tests that will be used to monitor this member and attach medical records with baseline functional test scores.
   _____
   _____

Section IV. 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*

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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 _____