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

Antiretroviral 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

Antiretroviral requested

☐ Cimduo (lamivudine/tenofovir disoproxil fumarate)
☐ nevirapine extended-release
☐ Selzentry (maraviroc)
☐ Symfi (efavirenz/lamivudine/tenofovir disoproxil fumarate)
☐ Symfi Lo (efavirenz/lamivudine/tenofovir disoproxil fumarate)
☐ Symtuza (darunavir/cobicistat/emtricitabine/ tenofovir alafenamide)
☐ Temixys (lamivudine/tenofovir disoproxil fumarate)
☐ tenofovir disoproxil fumarate tablet > 30 units/month
☐ Tivicay (dolutegravir) > 30 units/month
☐ Trogarzo (ibalizumab-uiyk)
☐ Viread (tenofovir disoproxil fumarate) powder ≥ 13 years of age

Dose, frequency, and duration of medication requested _____

Indication (Check all that apply.)

☐ HIV-1 Current viral load and date _____
☐ Chronic Hepatitis B ☐ Other (specify) _____

Is this member a referral candidate for care coordination? ☐ Yes ☐ No
If yes, MassHealth will offer care coordination services to this member. Please describe which additional behavioral health services would be beneficial.

_____

Section I. Please complete for Selzentry requests.

1. Is the member treatment naïve? ☐ Yes ☐ No
2. Did the member experience any of the following outcomes for medications used for the treatment of HIV/AIDS? ☐ Yes ☐ No

Drug _____ ☐ Adverse reaction ☐ Inadequate response
Drug _____ ☐ Adverse reaction ☐ Inadequate response
Drug _____ ☐ Adverse reaction ☐ Inadequate response

Briefly describe details of adverse reaction or inadequate response.

_____

3. Does the member have drug-resistant HIV-1?
   ☐ Yes. Please describe details of resistance to specific antiretroviral drugs. _____
   ☐ No
4. Please describe the member's current antiretroviral treatment plan.

   _____
5. Please provide the results of trofile assay indicating positive CCR5 tropic HIV-1 infection.

   _____
6. Is Selzentry (maraviroc) requested as part of a combination treatment regimen?
   ☐ Yes
   ☐ No. If Selzentry (maraviroc) is requested as monotherapy, please indicate why combination therapy is not indicated.

   _____

Section II. Please complete for requests for tenofovir disoproxil fumarate tablet > 30 units/month, and Viread powder ≥ 13 years of age.

Please describe the medical necessity for the agent selected. Please address need for the requested quantity (tenofovir disoproxil fumarate tablet), or use in the requested age group (Viread powder), as appropriate.

_____

_____

_____

Section III. Please complete for Tivicay requests > 30 units/month.

1. Will the member be taking the requested medication concurrently with carbamazepine, efavirenz, fosamprenavir/ritonavir, Aptivus (tipranavir)/ritonavir, or rifampin?
   ☐ Yes. Please document drug name with dose and frequency. ☐ No
   Drug _____ Dose and Frequency _____
2. Does the member have integrase strand transfer inhibitor (INSTI)-associated resistance substitutions or clinically suspected INSTI-resistance?
   ☐ Yes ☐ No

Section IV. Please complete for nevirapine extended-release requests.

Please attach medical records documenting an inadequate response or adverse reaction to nevirapine immediate-release formulation.

Section V. Please complete for Cimduo, Symfi, Symfi Lo, Symtuza, and Temixys requests.

For Symtuza, only question 1 is required.

1. Please provide clinical rationale for use of the combination product instead of the individual agents.

   _____

   _____

   _____
2. For members < 18 years of age, please provide member's current weight. _____
3. For Cimduo and Temixys, will the member be taking the requested medication concurrently with at least one other antiretroviral?
   ☐ Yes. Please document drug name with dose and frequency. ☐ No
   Drug _____ Dose and Frequency _____

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Section VI. Please complete for Trogarzo requests.

1. Does the member have resistance to an agent from each of the three classes of antiretrovirals [nucleoside analog reverse transcriptase inhibitor (NRTI), non-nucleoside reverse transcriptase inhibitor (NNRTI), protease inhibitor (PI)]?
   ☐ Yes. Please document drug names and outcomes.* ☐ No
   NRTI _____ ☐ Resistant ☐ Other
   NNRTI _____ ☐ Resistant ☐ Other
   PI _____ ☐ Resistant ☐ Other
   Briefly describe details of resistance or other.
   _____
2. Will the member be taking the requested medication concurrently with at least one other antiretroviral?
   ☐ Yes. Please document drug name with dose and frequency. ☐ No
   Drug _____ Dose and Frequency _____

** 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 _____