



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

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

Please complete the following for all requests.

- Member's current weight _____ Date _____
- Please indicate prescriber specialty. Allergy & immunology Dermatology Pulmonology
 Other (Please specify.) _____
- 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 _____
- 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 Xolair for the diagnosis of moderate-to-severe allergic asthma, and for Cinqair, Fasentra, and Nucala for the diagnosis of severe eosinophilic asthma.

For Xolair, please complete questions 1 through 3. For Cinqair, Fasentra, 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 histamine₁ 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 histamine₁ 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 histamine₂ antihistamine?
- 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 histamine₂ 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.

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 _____
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 _____