



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

Multiple Sclerosis 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

- | | | |
|---|--|---|
| <input type="checkbox"/> Aubagio (teriflunomide) | <input type="checkbox"/> Lemtrada (alemtuzumab) ^ | <input type="checkbox"/> Ocrevus (ocrelizumab) |
| <input type="checkbox"/> dalfampridine | <input type="checkbox"/> Mavenclad (cladribine tablet) | <input type="checkbox"/> Plegridy (peginterferon beta-1a) |
| <input type="checkbox"/> Extavia (interferon beta-1b) | <input type="checkbox"/> Mayzent (siponimod) | <input type="checkbox"/> Tecfidera (dimethyl fumarate) |
| <input type="checkbox"/> Gilenya (fingolimod) | | |

^ This drug is available through the health care professional who administers the drug. MassHealth does not pay for this drug to be dispensed through a retail pharmacy.

Dose, frequency, and duration of medication requested _____

Indication (Check all that apply.)

- Clinically Isolated Syndrome
 Multiple Sclerosis
 Subtype relapsing-remitting primary progressive non-active secondary progressive
 active secondary progressive (member has had a relapse in the past two years)
 Other (Please indicate.) _____

Is the prescriber a neurologist?

- Yes
 No. Please attach consultation notes from a neurologist addressing the use of the requested agent.

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 requests for Lemtrada.

Has the member had trials with two of the following agents: Aubagio, Gilenya, glatiramer, interferon formulations, Ocrevus, Tecfidera, or Tysabri?

- Yes. Please list the drug names, dates/duration of use, and outcomes in Section VIII below.*
 No. Please describe why the member is not a candidate for these agents.
-

Section II. Please complete for requests for dalfampridine.

Is the medication requested to improve walking distance in a member with multiple sclerosis?

- Yes
 No. Please describe the clinical rationale for using the requested medication below.
-

Section III. Please complete for requests for Mayzent.

1. Has the member had trials with two of the following agents: Aubagio, Gilenya, glatiramer, interferon formulations, Ocrevus, or Tecfidera?

- Yes. Please list the drug names, dates/duration of use, and outcomes in Section VIII below.*
 No. Please describe why the member is not a candidate for these agents.

2. Please indicate CYP2C9 genotype *1/*1 *1/*2 *1/*3 *2/*2 *2/*3 *3/*3 Other _____

Section IV. Please complete for requests for Extavia.

Please provide medical necessity for use instead of Betaseron (interferon beta-1b).

Section V. Please complete for requests for Plegridy.

1. Please provide medical necessity for use instead of interferon beta-1a (Avonex, Rebif).

2. Has the member had a trial with one of the following agents: Aubagio, Gilenya, glatiramer, Lemtrada, Ocrevus, Tecfidera, or Tysabri?

- Yes. Please list the drug name, dates/duration of use, and outcomes in Section VIII below.*
 No. Please describe why the member is not a candidate for these agents.
-

Section VI. Please complete for requests for Gilenya.

Please indicate: Member's current weight _____ Date _____

Section VII. Please complete for requests for Mavenclad.

Has the member had trials with three of the following agents: Aubagio, Gilenya, glatiramer, interferon formulations, Mayzent, Ocrevus, Tecfidera, or Tysabri?

- Yes. Please list the drug names, dates/duration of use, and outcomes in Section VIII below.*
 No. Please describe why the member is not a candidate for these agents.
-

Section VIII. Please complete for all requests as needed.

Please provide the following information regarding previous trials.*

Drug name _____ Dates/duration of use _____

Did the member experience any of the following? Adverse reaction Inadequate response

Briefly describe details of adverse reaction or inadequate response.

Drug name _____ Dates/duration of use _____

Did the member experience any of the following? Adverse reaction Inadequate response

Briefly describe details of adverse reaction or inadequate response.

Drug name _____ Dates/duration of use _____

Did the member experience any of the following? Adverse reaction Inadequate response

Briefly describe details of adverse reaction or inadequate response.

* Please attach a letter documenting additional trials as necessary.

Section IX. 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 _____