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

Targeted Immunomodulators 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

Anti-TNFs
- ☐ Avsola (infliximab-axxq)
- ☐ Cimzia (certolizumab)
- ☐ Enbrel (etanercept)
- ☐ Humira (adalimumab)
- ☐ Inflectra (infliximab-dyyb)
- ☐ Remicade (infliximab)
- ☐ Renflexis (infliximab-abda)
- ☐ Simponi (golimumab)
- ☐ Simponi Aria (golimumab for infusion)

Interleukin Antagonists
- ☐ Actemra (tocilizumab)
- ☐ Cosentyx (secukinumab)
- ☐ Ilumya (tildrakizumab-asmn)
- ☐ Kevzara (sarilumab)
- ☐ Kineret (anakinra)
- ☐ Siliq (brodalumab)
- ☐ Skyrizi (risankizumab-rzaa)
- ☐ Stelara (ustekinumab)
- ☐ Taltz (ixekizumab)
- ☐ Tremfya (guselkumab)

Miscellaneous Agents
- ☐ Entyvio (vedolizumab)
- ☐ Olumiant (baricitinib)
- ☐ Orencia (abatacept)
- ☐ Otezla (apremilast)
- ☐ Rinvoq (upadacitinib)
- ☐ Xeljanz (tofacitinib)
- ☐ Xeljanz XR (tofacitinib extended-release)

Dose, frequency, and duration of medication requested _____

Indication (Check all that apply.)
- ☐ Ankylosing spondylitis (AS)
  - ☐ Axial (spine) involvement
- ☐ Crohn's disease
  - ☐ Fistulizing Crohn's disease
- ☐ Cytokine release syndrome
- ☐ Giant cell arteritis (GCA)
- ☐ Hidradenitis suppurativa (HS) (Hurley Stage II or III)
- ☐ Juvenile idiopathic arthritis (JIA)
  - ☐ Polyarticular ☐ Systemic
- ☐ Neonatal-onset multisystem inflammatory disease (NOMID)
- ☐ Non-infectious uveitis
- ☐ Non-radiographic axial spondyloarthritis (nr-AxSpA)
- ☐ Oral ulcers associated with Behcet's disease
- ☐ Plaque psoriasis (PsO)
- ☐ Psoriatic arthritis (PsA)
  - ☐ Axial (spine) involvement
- ☐ Rheumatoid arthritis (RA)
- ☐ Ulcerative colitis (UC)
- ☐ Other _____

Please specify severity of indication below.

☐ Mild ☐ Mild-moderate ☐ Moderate ☐ Moderate-severe ☐ Severe

Please complete the following for all requests.

1. Member's current weight _____
2. 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 _____
3. Is the member stabilized on the requested medication? ☐ Yes. Please provide start date. _____ ☐ No

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Section I. Please complete for all requests, except for a diagnosis of cytokine release syndrome, GCA, HS (Hurley Stage II or III), NOMID, non-infectious uveitis, nr-AxSpA, or oral ulcers associated with Behcet's disease.

Has the member tried traditional or biologic disease modifying antirheumatic drugs (DMARDs)?

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

☐ No. Please explain why not. _____

Section II. Please also complete for treatment of PsO with Avsola, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Inflectra, Otezla, Remicade, Renflexis, Siliq, Skyrizi, Stelara, Taltz, or Tremfya.

Has the member tried other therapies to treat this condition including topical agents, systemic agents, and phototherapy?

☐ Yes. Please list the names of the therapies, dates/duration of trials and outcomes in Section VI below.*

☐ No. Please explain why not. _____

Section III. Please also complete for treatment of AS with anti-TNFs, Cosentyx, and Taltz. Please complete for treatment of nr-AxSpA with Cimzia, Cosentyx, and Taltz.

1. Has the member tried two nonsteroidal anti-inflammatory drugs (NSAIDs)?
   ☐ Yes. Please list the drug names, dates/duration of trials and outcomes in Section VI below.*
   ☐ No. Please explain why not. _____
2. If the request is for Cosentyx or Taltz, has the member tried one anti-TNF agent that is FDA-approved for the requested indication?
   ☐ Yes. Please list the drug names, dates/duration of trials and outcomes in Section VI below.*
   ☐ No. Please explain why not. _____

Section IV. Please complete for treatment of non-infectious uveitis with Humira and for treatment of GCA with Actemra.

Has the member tried other medications to treat this condition including glucocorticoid and immunosuppressive therapy?

☐ Yes. Please list the drug name, dates/duration of trials and outcomes in Section VI below.*

☐ No. Please explain why not. _____

Section V. Please complete for treatment of cytokine release syndrome with Actemra IV.

Please provide anticipated date of administration with concurrent CAR T-cell therapy. _____

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Section VI. Please complete for all requests as needed.

Please provide the following information regarding previous trials.*

Drug name/Therapy ______________________________ 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.

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Drug name/Therapy ______________________________ 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.

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Drug name/Therapy ______________________________ Dates/duration of use ___________________________

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

Briefly describe details of adverse reaction or inadequate response.

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Drug name/Therapy ______________________________ 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.

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Section VII. Please complete for requests for quantities above quantity limits.

Please describe the clinical rationale for exceeding the quantity limit.

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Section VIII. 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.

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

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 _____