



# Prior Authorization Request Administrative Information

## Member information

Last name  First name  MI

Member ID  Date of birth

Sex assigned at birth  Female  Male  "X" or Intersex

Current gender  Female  Male  Transgender male  Transgender female  Other

Place of residence  Home  Nursing facility  Other

Race  Ethnicity

Preferred spoken language  Preferred written language

MassHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, creed, sexual orientation, or sex (including gender identity and gender stereotyping).

## Plan contact information

Please indicate the member's MassHealth Plan and fax or submit this completed and signed form according to the Plan's contact information below.

### MassHealth Fee-For-Service (FFS) Plan, Primary Care Clinician (PCC) Plan, Primary Care Accountable Care Organization (PCACO) Plan, and Children's Medical Security Plan

**MassHealth Drug Utilization Review Program**  
Pharmacy: Fax: (877) 208-7428 - Tel: (800) 745-7318

### MassHealth Managed Care Organization (MCO) and Accountable Care Partnership Plans (ACPP)

**Fallon Health**  
Online Prior Authorization: [go.covermy meds.com/OptumRx](http://go.covermy meds.com/OptumRx)  
Online Prior Authorization: [providerportal.surescripts.net/ProviderPortal/optum](http://providerportal.surescripts.net/ProviderPortal/optum)  
Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033

**Health New England**  
Online Prior Authorization: [go.covermy meds.com/OptumRx](http://go.covermy meds.com/OptumRx)  
Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545

**Mass General Brigham Health Plan**  
Online Prior Authorization (Pharmacy Benefit Reviews): [go.covermy meds.com/OptumRx](http://go.covermy meds.com/OptumRx)  
Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555  
Online Prior Authorization (Medical Specialty Reviews): [provider.massgeneralbrighamhealthplan.org](http://provider.massgeneralbrighamhealthplan.org)  
Medical Specialty Reviews: Fax: (888) 656-6671 - Tel: (833) 895-2611

**Tufts Health Plan**  
Online Prior Authorization: [point32health.promptpa.com](http://point32health.promptpa.com)  
Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985

**WellSense Health Plan**  
Online Prior Authorization: [wellsense.org/providers/ma/pharmacy/prior-authorizations](http://wellsense.org/providers/ma/pharmacy/prior-authorizations)  
Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822

# Anti-Obesity 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](http://www.mass.gov/druglist).

## Medication information

### Medication Requested

- |   |   |
|---|---|
| <input type="checkbox"/> benzphetamine                                    | <input type="checkbox"/> phentermine 15 mg, 30 mg capsule < 12 years    |
| <input type="checkbox"/> diethylpropion                                   | <input type="checkbox"/> phentermine 37.5 mg capsule, tablet < 12 years |
| <input type="checkbox"/> diethylpropion ER                                | <input type="checkbox"/> phentermine/topiramate ER                      |
| <input type="checkbox"/> liraglutide (Saxenda)                            | <input type="checkbox"/> Wegovy (semaglutide injection)                 |
| <input type="checkbox"/> orlistat   | <input type="checkbox"/> Zepbound (tirzepatide)                         |
| <input type="checkbox"/> phendimetrazine                                  | <input type="checkbox"/> Other** <input type="text"/>                   |
| <input type="checkbox"/> phendimetrazine ER                               |   |
| <input type="checkbox"/> phentermine 8 mg tablet < 12 years or ≥ 18 years |   |

Dose and frequency of medication requested

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

Indication or ICD-10 code, if applicable

- |  |   |
|--|---|
| <input type="checkbox"/> Obesity*  | <input type="checkbox"/> Nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis                     |
| <input type="checkbox"/> Overweight*   | <input type="checkbox"/> Metabolic dysfunction-associated steatohepatitis (MASH) with moderate to advanced liver fibrosis |
| <input type="checkbox"/> Risk reduction of major adverse cardiovascular events with established cardiovascular disease and obesity or overweight | <input type="checkbox"/> Other** <input type="text"/>   |
| <input type="checkbox"/> Moderate to severe obstructive sleep apnea (OSA) with obesity   |   |

*\*Please note, liraglutide (generic Saxenda) is not covered for MassHealth members for the treatment of overweight or obesity for adults.*

*\*\*If other, please attach a letter documenting additional information as necessary or consider use of alternative PA form where appropriate*

## Section I. Please complete for all requests.

- Member's baseline weight  kg Date
- Member's current weight  kg Date
- Member's current height  cm Date
- Member's baseline BMI  kg/m<sup>2</sup> Date
- Member's current BMI  kg/m<sup>2</sup> Date
- Has the member been counseled to continue reduced-calorie diet and increased physical activity?  
 Yes  No

7. Does the member have any of the following weight-related comorbid conditions?

- Chronic kidney disease stage 3a or above  Yes  No
- Heart failure with preserved ejection fraction  Yes  No
- History of myocardial infarction  Yes  No
- History of stroke  Yes  No
- Non-alcoholic steatohepatitis (NASH)  Yes  No
- Noncirrhotic metabolic dysfunction associated steatohepatitis (MASH)  Yes  No
- Moderate or severe obstructive sleep apnea  Yes  No
- Prediabetes  Yes  No
- Symptomatic peripheral artery disease  Yes  No
- Type 2 diabetes mellitus  Yes  No
- Uncontrolled hypertension  Yes  No
- Other comorbidity   Yes  No

8. For liraglutide (generic Saxenda), Wegovy and Zepbound requests, will the requested agent be used in combination with another GLP-1 receptor agonist?  Yes  No

9. For members < 12 years of age for phentermine 8 mg tablet and phentermine requests, please provide medical necessity to support the use of phentermine in a member < 12 years of age.

10. For benzphetamine, diethylpropion, diethylpropion ER, liraglutide (generic Saxenda) for members ≥ 12 years and < 18 years of age, phentermine 8 mg tablet, phendimetrazine and phendimetrazine ER, requests, has the member had a trial with phentermine with or without topiramate?

Yes. Please list the dates/duration of trials and outcomes below. If the member had an adverse reaction, please attach medical records documenting adverse reaction.

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, or other.

No. Please attach medical records documenting a contraindication to phentermine.

11. For liraglutide (generic Saxenda) for members ≥ 12 years and < 18 years of age, has the member had a trial with Wegovy?

Yes. Please list the dates/duration of trials and outcomes below. If the member had an adverse reaction, please attach medical records documenting adverse reaction.

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, or other.

No. Please attach medical records documenting a contraindication to Wegovy.

12. For phentermine/topiramate ER, please provide medical necessity for the combination product instead of the individual agents.

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**Section II. Please also complete for indication of nonalcoholic steatohepatitis (NASH) or metabolic dysfunction-associated steatohepatitis (MASH), with moderate to advanced liver fibrosis for Wegovy requests.**

1. Please provide medical records from liver biopsy or noninvasive testing (NIT) supporting the diagnosis of NASH or MASH, with moderate to advanced liver fibrosis.

2. Has the member been counseled to limit alcohol use?  Yes  No

3. Will the requested agent be used in combination with Rezdiffra?  Yes  No

If yes, is the member stable on combination therapy with Rezdiffra and a GLP-1 receptor agonist?

Yes  No

If no, did the member have an inadequate response to Rezdiffra monotherapy for at least one year and Wegovy 2.4 mg monotherapy for at least six months?

Yes. Please describe the dates/duration of use.

Dates/duration of use for Rezdiffra monotherapy trial

Dates/duration of use for Wegovy 2.4 mg monotherapy trial

No

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**Section III. Please complete for recertification requests.**

For recertification requests for Wegovy and Zepbound for members  $\geq 18$  years of age for all indications except for NASH or MASH, please complete questions 1 – 7.

1. Member's current weight

Date

2. Does the member have improvement in measures of comorbid conditions?  Yes  No

If yes, please describe.

3. Does the member have improvement in measures of comorbid conditions believed to be related to anti-obesity therapy despite lack of reduction in body weight?  Yes  No

If yes, please describe.

4. Does the member require use of Wegovy or Zepbound for cardiovascular protection and the benefit of cardiovascular protection outweighs the risk associated with use of GLP-1 agents?

Yes, please explain and provide medical records documenting cardiovascular condition(s).

No

5. Does the member have improvement in OSA symptoms, such as less daytime sleepiness, fewer sleep arousals, or fewer partner-reported snoring episodes or pauses in breathing?  Yes  No

If yes, please describe and provide medical records with baseline or current OSA diagnosis.

6. Does the member have improvement in OSA symptoms believed to be related to anti-obesity therapy despite lack of reduction in body weight?  Yes  No

7. Does the member have improvement in secondary measures believed to be related to anti-obesity therapy despite lack of reduction in body weight?  Yes  No

8. For Wegovy recertification requests, for the indication of NASH or MASH with moderate to advanced liver fibrosis, please document laboratory or imaging testing that indicates a positive response to therapy.

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**Section IV. Please complete for GLP-1 and GIP/GLP-1 agonist polypharmacy requests.**

Please complete information for medications requested and select the reason for polypharmacy.

1. Drug name  Dates/duration of use
2. Drug name  Dates/duration of use
- Member is transitioning from one GLP-1 or GIP/GLP-1 agonist to another and prior GLP-1 or GIP/GLP-1 agonist use will be discontinued.
- Other, please explain.
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**Section V. Please complete and provide documentation for exceptions to step therapy.**

1. Is the alternative drug required under the step therapy protocol contraindicated, or will likely cause an adverse reaction in, or physical or mental harm to, the member?  Yes  No
- If yes, briefly describe details of contraindication, adverse reaction, or harm.
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2. Is the alternative drug required under the step therapy protocol expected to be ineffective based on the known clinical characteristics of the member and the known characteristics of the alternative drug regimen?  Yes  No
- If yes, briefly describe details of known clinical characteristics of member and alternative drug regimen.
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3. Has the member previously tried the alternative drug required under the step therapy protocol, or another alternative drug in the same pharmacologic class or with the same mechanism of action, and such alternative drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?  Yes  No
- If yes, please provide details for the previous trial.
- 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.
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4. Is the member stable on the requested prescription drug prescribed by the health care provider, and switching drugs will likely cause an adverse reaction in, or physical or mental harm to, the member?  Yes. Please provide details.
- No

# Prior Authorization Request Prescriber and Provider Information

## Prescriber information

Last name*	<input type="text"/>	First name*	<input type="text"/>	MI	<input type="text"/>
NPI*	<input type="text"/>	Individual MH Provider ID	<input type="text"/>		
DEA No.	<input type="text"/>	Office Contact Name	<input type="text"/>		
Address	<input type="text"/>	City	<input type="text"/>	State	<input type="text"/>
		Zip	<input type="text"/>		
E-mail address	<input type="text"/>				
Telephone No.*	<input type="text"/>				
Fax No.* (Please provide fax number for PA response notification.)	<input type="text"/>				

\* Required

## Please also complete for professionally administered medications, if applicable.

Start date	<input type="text"/>	End date	<input type="text"/>		
Servicing prescriber/facility name	<input type="text"/>	<input type="checkbox"/>	Same as prescribing provider		
Servicing provider/facility address	<input type="text"/>				
Servicing provider NPI/tax ID No.	<input type="text"/>				
Name of billing provider	<input type="text"/>				
Billing provider NPI No.	<input type="text"/>				
Is this a request for recertification?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
CPT code	<input type="text"/>	No. of visits	<input type="text"/>	J code	<input type="text"/>
		No. of units	<input type="text"/>		

## Provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am either the prescribing provider or duly authorized to act on behalf of the provider identified in the Prescriber information section of this form. Any attached statement on 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.

### Signature of provider or individual duly authorized to act on behalf of the provider:

Printed legal name and title of signatory above

<input type="text"/>	Date	<input type="text"/>
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(The form can either be signed by hand and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.)