



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
<input type="checkbox"/> 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)
<input type="checkbox"/> Fallon Health Online Prior Authorization: go.covermymeds.com/OptumRx Online Prior Authorization: providerportal.surescripts.net/ProviderPortal/optum Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033
<input type="checkbox"/> Health New England Online Prior Authorization: go.covermymeds.com/OptumRx Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545
<input type="checkbox"/> Mass General Brigham Health Plan Online Prior Authorization (Pharmacy Benefit Reviews): go.covermymeds.com/OptumRx Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555 Online Prior Authorization (Medical Specialty Reviews): provider.massgeneralbrighamhealthplan.org Medical Specialty Reviews: Fax: (888) 656-6671 - Tel: (833) 895-2611
<input type="checkbox"/> Tufts Health Plan Online Prior Authorization: point32health.promptpa.com Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985
<input type="checkbox"/> WellSense Health Plan Online Prior Authorization: wellsense.org/providers/ma/pharmacy/prior-authorizations Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822

Oral Antibiotics and Anti-Infectives 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.

Medication information

Medication requested

- | | |
|---|---|
| <input type="checkbox"/> amoxicillin/clavulanate chewable tablet | <input type="checkbox"/> doxycycline monohydrate 150 mg capsule |
| <input type="checkbox"/> amoxicillin/clavulanate extended-release | <input type="checkbox"/> doxycycline monohydrate 150 mg tablet |
| <input type="checkbox"/> Augmentin (amoxicillin/clavulanate 125/31.25 mg/5 mL suspension) | <input type="checkbox"/> Egaten (triclabendazole) |
| <input type="checkbox"/> azithromycin powder packet | <input type="checkbox"/> erythromycin delayed-release capsule |
| <input type="checkbox"/> Baxdela (delafloxacin tablet) | <input type="checkbox"/> Krintafel (tafenoquine) > 2 units/365 days |
| <input type="checkbox"/> Blujepa (gepotidacin) | <input type="checkbox"/> Lampit (nifurtimox) |
| <input type="checkbox"/> cefaclor extended-release | <input type="checkbox"/> Likmez (metronidazole oral suspension) |
| <input type="checkbox"/> cefaclor suspension | <input type="checkbox"/> linezolid suspension |
| <input type="checkbox"/> cefadroxil tablet | <input type="checkbox"/> mebendazole |
| <input type="checkbox"/> cefixime | <input type="checkbox"/> metronidazole 125 mg tablet |
| <input type="checkbox"/> cefpodoxime suspension | <input type="checkbox"/> metronidazole 375 mg capsule |
| <input type="checkbox"/> cephalixin 750 mg capsule | <input type="checkbox"/> minocycline extended-release 45 mg, 55 mg, 65 mg, 80 mg, 90 mg, 115 mg |
| <input type="checkbox"/> cephalixin tablet | <input type="checkbox"/> minocycline tablet |
| <input type="checkbox"/> ciprofloxacin 100 mg tablet | <input type="checkbox"/> nitazoxanide tablet |
| <input type="checkbox"/> clarithromycin extended-release | <input type="checkbox"/> nitrofurantoin 25 mg/5 mL suspension |
| <input type="checkbox"/> Coartem (artemether/lumefantrine) > 24 units/365 days | <input type="checkbox"/> nitrofurantoin 50 mg/5 mL suspension |
| <input type="checkbox"/> Difucid (fidaxomicin) | <input type="checkbox"/> Nuzyra (omadacycline tablet) |
| <input type="checkbox"/> Doryx (doxycycline hyclate delayed-release 60 mg tablet) | <input type="checkbox"/> ofloxacin tablet |
| <input type="checkbox"/> doxycycline hyclate 50 mg tablet | <input type="checkbox"/> Orlynvah (sulopenem etzadroxil/probenecid) |
| <input type="checkbox"/> doxycycline hyclate delayed-release 50 mg, 75 mg, 80 mg, 100 mg, 150 mg, 200 mg tablet | <input type="checkbox"/> Pivya (pivmecillinam) |
| <input type="checkbox"/> doxycycline monohydrate 40 mg capsule | <input type="checkbox"/> pyrimethamine |
| <input type="checkbox"/> doxycycline monohydrate 75 mg capsule | <input type="checkbox"/> Sivextro (tedizolid tablet) |
| | <input type="checkbox"/> Solosec (secnidazole) |
| | <input type="checkbox"/> Sovuna (hydroxychloroquine) |
| | <input type="checkbox"/> tetracycline tablet |

Dose, frequency, and duration of medication requested

Indication or ICD-10 code, if applicable

Section I. Please complete for all requests.

1. Is the member under the care of an infectious disease specialist? Yes No

2. Please list previous trials for the requested indication including outcomes.*

Drug	<input type="text"/>	Outcome	<input type="text"/>	Dates of use	<input type="text"/>
Drug	<input type="text"/>	Outcome	<input type="text"/>	Dates of use	<input type="text"/>
Drug	<input type="text"/>	Outcome	<input type="text"/>	Dates of use	<input type="text"/>

*Attach a letter with additional information regarding medication trials as applicable.

Section II. Please complete for all requests for antibiotics.

1. Please indicate the infecting organism.

<input type="checkbox"/> Clostridium difficile	<input type="checkbox"/> Vancomycin-resistant Enterococcus (VRE)
<input type="checkbox"/> Fulminant disease	<input type="checkbox"/> Other <input type="text"/>
<input type="checkbox"/> Non-fulminant disease	
<input type="checkbox"/> Methicillin-resistant Staphylococcus aureus (MRSA)	

2. Is the infecting organism confirmed or suspected? Confirmed Suspected

3. Were cultures and susceptibility testing performed?

Yes. Please attach a copy of the culture and sensitivity report with submission.

No. Please provide clinical rationale why cultures and susceptibility testing were not performed.

Section III. Please also complete for requests for amoxicillin/clavulanate extended-release, cefaclor extended-release, and clarithromycin extended-release.

Please describe the medical necessity for the use of an extended-release dosage formulation instead of immediate-release formulations of the requested agent. Please describe prior trials and outcomes with the immediate-release formulation and additional antibiotics, if applicable, in Section I above.

Section IV. Please also complete for requests for amoxicillin/clavulanate chewable tablet, azithromycin powder packet, cefadroxil tablet, cefpodoxime suspension, cephalexin 750 mg capsule, cephalexin tablet, ciprofloxacin 100 mg tablet, erythromycin DR capsule, metronidazole 375 mg, and tetracycline tablet.

Please describe prior trials and outcomes with formulations of the requested antibiotic that are available without PA in Section I above. Please describe medical necessity for the use of the requested antibiotic instead of alternative strengths available without PA.

Section V. Please also complete for requests for doxycycline agents requiring PA.

Please describe prior trials and outcomes with doxycycline formulations that are available without PA in Section I above. Please describe medical necessity for the requested formulation instead of doxycycline formulations available without PA.

Section VI. Please also complete for requests for cefixime.

1. For suspension formulation, please describe medical necessity for the requested formulation.

2. Is the member completing a course of therapy that was initiated in the hospital? Yes No
If the answer to the above question is no, has the member had a trial with cefdinir or cefpodoxime?
 Yes. Please describe prior trials and outcomes in Section I above.

No. Please explain why not.

Section VII. Please also complete for requests for Sivextro tablet.

1. For Sivextro for the diagnosis of VRE, has the member had a trial with linezolid?

Yes. Please describe prior trials and outcomes in Section I above.

No. Please explain why not.

2. For the diagnosis of MRSA, has the member had a trial with clindamycin, doxycycline or minocycline, sulfamethoxazole/trimethoprim, or vancomycin IV?

Yes. Please describe prior trials and outcomes in Section I above.

No. Please explain why not.

Section VIII. Please also complete for requests for minocycline extended-release 45 mg, 55 mg, 65 mg, 80 mg, 90 mg, 115 mg tablets, and minocycline tablets.

1. For minocycline immediate-release tablet, please describe prior trials and outcomes with minocycline capsules in Section I above. Please describe medical necessity for the dosage formulation instead of immediate-release capsules.

2. For minocycline extended-release tablet and capsule formulations, has the member had a trial with minocycline capsules and minocycline extended-release 105 mg or 135 mg tablets?

Yes. Please describe prior trials and outcomes in Section I above.

No. Please explain why not.

Section IX. Please also complete for requests for cefaclor suspension, linezolid suspension, nitrofurantoin 25 mg/5 mL suspension, and nitrofurantoin 50 mg/5 mL suspension.

Please describe medical necessity for use of the suspension formulation.

Section X. Please also complete for requests for Augmentin 125/31.25 mg/5 mL suspension.

Please provide clinical rationale for not using 250/62.5 mg/5 mL formulation.

Section XI. Please also complete for requests for Baxdela tablet and Nuzyra tablet.

1. For suspected or confirmed MRSA infections or mixed pathogen infections (including MRSA), has the member had a trial with clindamycin, doxycycline or minocycline, linezolid, sulfamethoxazole/trimethoprim, or vancomycin IV?

Yes. Please describe prior trials and outcomes in Section I above.

No. Please explain why not.

2. For suspected or confirmed mixed pathogen infections (including MRSA), has the member had a trial with at least one other antibiotic with gram-negative coverage available without PA?

Yes. Please describe prior trials and outcomes in Section I above.

No. Please explain why not.

Section XII. Please also complete for requests for ofloxacin tablet.

Has the member had a trial with ciprofloxacin or levofloxacin?

Yes. Please describe prior trials and outcomes in Section I above.

No. Please explain why not.

Section XIII. Please also complete for requests for Coartem > 24 units/365 days and Krintafel (tafenoquine) > two units/365 days.

1. Please describe the medical necessity for exceeding the quantity limit.

2. For Krintafel, is the member currently receiving chloroquine therapy?

Yes.

No. Please explain why not.

Section XIV. Please also complete for requests for Lampit.

Member's current weight

Date

Section XV. Please also complete for requests for pyrimethamine.

Will the requested agent be used in combination with other agents for the diagnosis?

Yes. Please provide drug name(s).

No

Section XVI. Please also complete for requests for Likmez, metronidazole 125 mg tablet, and Sovuna.

1. For Likmez, please describe prior trials and outcomes with metronidazole tablets in Section I above.

2. For metronidazole 125 mg tablet, please describe prior trial and outcome with Likmez in Section I above.

3. Please describe medical necessity for the requested formulation.

Section XVII. Please also complete for requests for Blujepa, Orlynvah, and Pivya.

1. For Blujepa, please provide the member's current weight.

2. For Blujepa and Orlynvah, has the member had a trial with a beta-lactam, a fluoroquinolone, nitrofurantoin, and sulfamethoxazole/trimethoprim?

Yes. Please describe prior trials and outcomes in Section I above.

No. Please explain why not.

over

3. For Orlynvah, has the member had a trial with Blujepa?
 - Yes. Please describe prior trials and outcomes in Section I above.
 - No. Please explain why not.
4. For Pivya, has the member had a trial with two of the following: fosfomycin, nitrofurantoin, sulfamethoxazole/trimethoprim?
 - Yes. Please describe prior trials and outcomes in Section I above.
 - No. Please explain why not.
5. For requests exceeding quantity limits, please provide medical necessity for dosing.

Section XVIII. 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.
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.
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.
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

Please continue to next page and complete Prescriber and Provider Information section.

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.)