



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

Diabetes Medical Supplies 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.

Product information

Device requested

- Cequr Simplicity
 - Cequr Simplicity 2U 4-Day Patch
 - Cequr Simplicity Inserter
- Dexcom G6
 - Receiver
 - Sensor
 - Transmitter
- Dexcom G7
 - Receiver
 - Sensor
- Dexcom G7 15 Day
 - Sensor
- Freestyle Libre 14 Day
 - Reader
 - Sensor
- Freestyle Libre 2
 - Reader
 - Sensor
 - Sensor Plus
- Freestyle Libre 3
 - Reader
 - Sensor
 - Sensor Plus

- Omnipod 5
 - Omnipod 5 Pod Pack
 - Omnipod 5 Intro Kit

Please specify brand (e.g., G6/G7, G6/Libre 2 Plus)
- Omnipod Dash
 - Omnipod Dash Intro Kit
 - Omnipod Dash Personal Diabetes Manager
 - Omnipod Dash Pod Pack

Non-drug product requested Qty/30 days

- Blood glucose testing strips > 100 units/30 days
 - Freestyle
 - Freestyle Insulinx
 - Freestyle Lite
 - Freestyle Neo
 - Precision Xtra
- Non-preferred blood glucose testing strips (Please specify brand.)

Dose, frequency, and duration of medication or medical supplies requested

Indication (Check all that apply or include ICD-10 code, if applicable.)

- Type 1 Diabetes Mellitus Type 2 Diabetes Mellitus Other

What is the member's most recent hemoglobin A1C? Date

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. *Please inform the member, parent, or legal guardian to expect outreach from a MassHealth representative of care coordination services.*

Section I. Please complete for Dexcom G6, Dexcom G7, Freestyle Libre 14 Day, Freestyle Libre 2, and Freestyle Libre 3 requests.

1. Is the member stabilized on the requested device? Yes. Please provide start date. No
2. Is the member currently receiving treatment with insulin administration or an insulin pump? Yes No

Please explain.

3. Has the member experienced any of the following? (Check all that apply.)

Yes

- Two hypoglycemic events with blood glucose of < 54 mg/dL (3.0mmol/L) within the last 12 months
- One hypoglycemic event with blood glucose of < 54 mg/dL (3.0mmol/L) that required third-party assistance for treatment within the past 12 months
- Glycosylated hemoglobin (HbA1c) \geq 7% or at a value that does not meet documented target treatment
- Frequent hypoglycemia or nocturnal hypoglycemia
- History of hypoglycemia unawareness
- Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL
- History of emergency room visit or hospitalization related to ketoacidosis

No. Please explain why the member is a candidate for continuous blood glucose monitoring.

Section II. Please complete for Cequr Simplicity, Omnipod 5, and Omnipod Dash requests.

1. Is the member stabilized on the requested device? Yes. Please provide start date. No
2. Is the member currently testing blood glucose at least four times per day or using continuous glucose monitoring? Yes No
3. Is the member currently receiving treatment with insulin administration at least three times per day or an insulin pump? Yes No

Section III. Please complete for Cequr Simplicity, Dexcom G6, Dexcom G7, Freestyle Libre 14 Day, Freestyle Libre 2, Freestyle Libre 3, Omnipod 5, and Omnipod Dash recertification requests.

For Cequr Simplicity, Omnipod 5, and Omnipod Dash, question 1 and 3 are required.

1. Has the member demonstrated improvement in diabetic control or relative stability?

Yes

No. Please describe why not.

2. Has the member's continuous blood glucose monitoring data been reviewed and used to monitor or adjust the antidiabetic treatment plan?

Yes

No. Please describe why not.

3. For intro kits/personal diabetes managers, please provide clinical rationale why replacement is not covered by manufacturer warranty.

Section IV. Please complete for all requests exceeding the quantity limit.

1. Is the member currently receiving treatment with insulin administration or an insulin pump?

Yes. Please provide units/day.

No

2. Does the member exhibit any of the following clinical characteristics? (Check all that apply.)

Yes

Injection site irritation. Were mitigation strategies attempted? Yes No

Adhesion failure. Were mitigation strategies attempted? Yes No

Lipoatrophy or lipohypertrophy at the injection site

Pooling of insulin at the injection site

No. Please provide medical necessity for the requested quantity.

3. Has the member or the member's caregiver been trained on appropriate application including washing, cleaning, and allowing the skin to dry completely before applying product. Yes No

4. For Dexcom and Freestyle Libre sensor requests, please provide clinical rationale why sensor changes are required more frequently than labelled frequency.

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.

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

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.)