



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

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.

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"/> Wegovy (semaglutide tablet) |
| <input type="checkbox"/> phendimetrazine | <input type="checkbox"/> Zepbound (tirzepatide) |
| <input type="checkbox"/> phendimetrazine ER | <input type="checkbox"/> Other** <input type="text"/> |
| <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/m² Date
- Member's current BMI kg/m² 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 injection?

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 injection.

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 injection 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 Rezdifra? Yes No

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

Yes No

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

Yes. Please describe the dates/duration of use.

Dates/duration of use for Rezdifra monotherapy trial

Dates/duration of use for Wegovy 2.4 mg injection monotherapy trial

No

Section III. Please complete for recertification requests.

For recertification requests for Wegovy and Zepbound for members ≥ 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 injection 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.

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.
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.)