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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.covermymeds.com/OptumRx Online Prior Authorization: providerportal.surescripts.net/ProviderPortal/optum Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033
☐ **Health New England** Online Prior Authorization: go.covermymeds.com/OptumRx Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545
☐ **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
☐ **Tufts Health Plan** Online Prior Authorization: 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 Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822

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Antidiabetic 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 (Check one or all that apply. Where applicable, the brand name is provided in brackets for reference.)

Single Injectable Agents

- ☐ Bydureon Bcise (exenatide extended-release auto-injection)
- ☐ exenatide injection
- ☐ liraglutide [Victoza]
- ☐ Mounjaro (tirzepatide)
- ☐ Ozempic (semaglutide injection)
- ☐ Trulicity (dulaglutide)
- ☐ Tzield (teplizumab-mzwv)

Single Oral Agents

- ☐ alogliptin
- ☐ Brynovin (sitagliptin solution)
- ☐ glimepiride 3 mg tablet
- ☐ glipizide 2.5 mg tablet
- ☐ Inpefa (sotagliflozin)
- ☐ Invokana (canagliflozin)
- ☐ Januvia (sitagliptin)
- ☐ metformin extended-release, gastric tablet [Glumetza]
- ☐ metformin extended-release, osmotic tablet
- ☐ metformin immediate-release 625 mg, 750 mg tablet
- ☐ metformin immediate-release solution ≥ 13 years
- ☐ miglitol
- ☐ Riomet ER (metformin extended-release suspension)
- ☐ Rybelsus (semaglutide tablet)
- ☐ saxagliptin
- ☐ Steglatro (ertugliflozin)
- ☐ Zituvio (sitagliptin)

Combination Injectable Agents

- ☐ Soliqua (insulin glargine/lixisenatide)
- ☐ Xultophy (insulin degludec/liraglutide)

Insulin Agents

- ☐ Admelog (insulin lispro)
- ☐ Afrezza (insulin human inhalation powder)
- ☐ Apidra (insulin glulisine)
- ☐ Basaglar (insulin glargine)
- ☐ Basaglar Tempo (insulin glargine)
- ☐ Fiasp (insulin aspart)
- ☐ Humalog (insulin lispro 200 units/mL)
- ☐ Humalog Tempo (insulin lispro)
- ☐ Humulin N (insulin NPH)
- ☐ insulin glargine-yfgn
- ☐ Kirsty (insulin aspart-xjhz)
- ☐ Lyumjev (insulin lispro-aabc)
- ☐ Lyumjev Tempo (insulin lispro-aabc)
- ☐ Merilog (insulin aspart-szjj)
- ☐ Novolin (insulin NPH/regular insulin 70/30)
- ☐ Novolog (insulin aspart)
- ☐ Rezvoglar (insulin glargine-aglr)
- ☐ Toujeo (insulin glargine)
- ☐ Tresiba (insulin degludec)

Combination Oral Agents

- ☐ alogliptin/metformin
- ☐ alogliptin/pioglitazone
- ☐ Glyxambi (empagliflozin/linagliptin)
- ☐ Invokamet (canagliflozin/metformin)
- ☐ Invokamet XR (canagliflozin/metformin extended-release)
- ☐ Janumet (sitagliptin/metformin)
- ☐ Janumet XR (sitagliptin/metformin extended-release)
- ☐ pioglitazone/glimepiride
- ☐ Qtern (dapagliflozin/saxagliptin)
- ☐ repaglinide/metformin
- ☐ saxagliptin/metformin extended-release
- ☐ Segluromet (ertugliflozin/metformin)
- ☐ sitagliptin/metformin
- ☐ sitagliptin/metformin extended-release
- ☐ Steglujan (ertugliflozin/sitagliptin)
- ☐ Trijardy XR (empagliflozin/linagliptin/metformin extended-release)

Other Medication

☐ Other*† _____

**If request is for a non-preferred brand name or generic product, please attach supporting documentation (e.g., copies of medical records and/or office notes regarding adverse reaction or inadequate response to the preferred product).*

Dose and frequency of medication requested _____

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

☐ Type 1 Diabetes Mellitus ☐ Type 2 Diabetes Mellitus ☐ Prediabetes

☐ Stage _____

Member's baseline hemoglobin A1C, prior to initiation of the requested agent _____ Date _____

Member's most recent hemoglobin A1C _____ Date _____

☐ Reduction of risk of cardiovascular death, hospitalization for heart failure, and urgent heart failure visit

☐ Type 2 diabetes mellitus and diabetic nephropathy with albuminuria

☐ Cardiovascular risk factors _____

☐ Chronic kidney disease

What is the member's most recent eGFR? _____ Date _____

What is the member's most recent urinary albumin-to-creatinine ratio? _____

☐ Other† _____

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

Please list all other antidiabetic medications currently prescribed for the member for this indication.

Drug _____ Dose and Frequency _____ Dates of use _____

Drug _____ Dose and Frequency _____ Dates of use _____

Drug _____ Dose and Frequency _____ Dates of use _____

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 combination oral agents.

1. Has the member tried metformin used in combination with at least one of the non-metformin agents in the requested combination?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XXV below.* ☐No
2. If the answer to question 1 is no, has the member tried metformin?
   ☐ Yes. Please list the drug name, dates/duration of use, and outcome in Section XXV below.* ☐No
3. If the answer to question 1 is no, has the member tried at least one of the non-metformin agents in the requested combination?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XXV below.* ☐No

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4. For Trijardy XR, please provide medical necessity for use instead of the commercially-available separate agents.

Section II. Please complete for single and combination injectable agents (excluding liraglutide [generic Victoza], Mounjaro, Ozempic, Trulicity, and Tzield) and Rybelsus.

For requests for Bydureon Bcise, exenatide, Rybelsus, Soliqua and Xultophy, please complete questions 1-5. For Rybelsus 1.5 mg, 4 mg and 9 mg tablets please complete questions 1-6. Please include doses with all trial documentation. For recertification requests, please also complete Section XXVII below.

1. For requests for Bydureon Bcise, exenatide, Rybelsus, Soliqua, and Xultophy, has the member tried metformin used in combination with liraglutide (generic Victoza), Trulicity, and Mounjaro or Ozempic?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XXV below.* ☐ No
2. If the answer to question 1 is no, has the member tried metformin?
   ☐ Yes. Please list the drug name, dates/duration of use, and outcome in Section XXV below.* ☐ No
   If No, please explain why not.
3. If the answer to question 1 is no, has the member tried liraglutide (generic Victoza), Trulicity, and Mounjaro or Ozempic?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XXV below.*
   ☐ No. Please describe if there is a contraindication to liraglutide (generic Victoza), Mounjaro, Ozempic, and Trulicity.
4. If the request is for quantities exceeding the quantity limit, please complete Section XXIV below.
5. For Bydureon Bcise, exenatide, Rybelsus, Soliqua, and Xultophy, will the requested agent be used in combination with a GLP-1 receptor agonist? ☐ Yes. If yes, please complete Section XXVI below. ☐ No
6. For Rybelsus 1.5 mg, 4 mg and 9 mg, please provide medical necessity for the requested formulation instead of Rybelsus 3 mg, 7 mg, and 14 mg tablets.

Section III. Please complete for liraglutide [generic Victoza], Mounjaro, Ozempic, or Trulicity requests. For recertification requests, please also complete Section XXIV below.

1. Will the requested agent be used in combination with another GLP-1 receptor agonist?
   ☐ Yes. If yes, complete Section XXVI below. ☐ No
2. If the request is for quantities exceeding the quantity limit, please complete Section XXIV below.
3. If the request is for prediabetes, has the member tried metformin?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XXV below.* ☐ No
   If No, please explain why not.
4. For Ozempic for a diagnosis of type 2 diabetes mellitus and chronic kidney disease, will the requested agent be used in combination with an angiotensin-converting–enzyme inhibitor (ACE-I) or angiotensin-receptor blocker (ARB)? ☐ Yes ☐ No
   If No, please describe if there is a contraindication to ACE-I and ARB medications.

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5. For Ozempic for a diagnosis of type 2 diabetes mellitus and chronic kidney disease, has the member tried dapagliflozin or Jardiance? ☐ Yes ☐ No
   If No, please describe if there is a contraindication to dapagliflozin and Jardiance.

Section IV. Please complete for alogliptin, saxagliptin, and Zituvio requests.

1. Has the member tried metformin used in combination with Januvia or Tradjenta?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XXV below.* ☐No
2. If the answer to question 1 is no, has the member tried metformin?
   ☐ Yes. Please list the drug name, dates/duration of use, and outcome in Section XXV below.* ☐No
3. If the answer to question 1 is no, has the member tried Januvia or Tradjenta?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XXV below.*
   ☐ No. Please describe if there is a contraindication to Januvia and Tradjenta.
4. If the request is for greater than one tablet per day, please complete Section XXIV below.

Section V. Please complete for glimepiride 3 mg tablet requests.

Please provide medical necessity for the use of the requested agent instead of glimepiride tablets that are available without prior authorization.

Section VI. Please complete for Invokana and Steglatro requests.

For Invokana for type 2 diabetes mellitus and diabetic nephropathy with albuminuria requests, only question 4 is required.

1. Has the member tried metformin used in combination with dapagliflozin or Jardiance?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XXV below.* ☐No
2. If the answer to question 1 is no, has the member tried metformin?
   ☐ Yes. Please list the drug name, dates/duration of use, and outcome in Section XXV below.* ☐No
3. If the answer to question 1 is no, has the member tried dapagliflozin or Jardiance?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XXV below.*
   ☐ No. Please describe if there is a contraindication to dapagliflozin and Jardiance.
4. If the request is for greater than one tablet per day, please complete Section XXIV below.

Section VII. Please complete for Tzield requests.

1. Is the prescriber an endocrinologist? ☐ Yes ☐ No. Please attach consultation notes from an endocrinologist addressing the use of the requested agent.
2. Please attach lab results documenting ≥ two islet autoantibodies.
3. Please complete the below lab test results as applicable.

   Fasting Plasma Glucose (FPG) Date obtained

   2-hour Plasma Glucose (2-h PG) Date obtained

   A1C: please document lab values from previous 12 months below.

   Lab value Date obtained

   Lab value Date obtained

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4. Has the member been treated with Tzield previously? ☐ Yes ☐ No

Section VIII. Please complete for Basaglar and Basaglar Tempo requests.

1. Has the member had an inadequate response or adverse reaction to insulin glargine (generic Lantus) prefilled syringe or vial?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XXV below.* ☐No
2. Has the member had an inadequate response or adverse reaction to insulin glargine-vfgn prefilled syringe or vial or Rezvoglar?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XXV below.* ☐No
3. For Basaglar Tempo, please provide medical necessity for use of the Tempo Pen formulation instead of the KwikPen formulation.

Section IX. Please complete for insulin glargine-vfgn, Rezvoglar, Toujeo, and Tresiba requests.

Please provide medical necessity for use of requested agent instead of the insulin glargine prefilled syringe or vial (branded or unbranded Lantus).

Section X. Please complete for Admelog, Apidra, Fiasp, Kirsty, Lyumjev, Lyumjev Tempo, Merilog, and Novolog requests.

1. Has the member had a trial with insulin lispro (generic Humalog)?
   ☐ Yes. Please list the drug name, dates/duration of use, and outcomes in Section XXV below.* ☐No
2. For Kirsty and Merilog, please provide medical necessity for use of the requested agent instead of Novolog.
3. For Lyumjev Tempo, please provide medical necessity for use of the Tempo Pen formulation instead of the KwikPen formulation.

Section XI. Please complete for Afrezza requests.

Please provide medical necessity for the use of an inhaled insulin product instead of an injectable or prefilled insulin syringe.

Section XII. Please complete for Humalog Tempo requests.

Please provide medical necessity for use of the Tempo Pen formulation instead of the KwikPen formulation.

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Section XIII. Please complete for Humulin (insulin lispro 200 units/mL) requests.

Please provide medical necessity for use of requested agent instead of the 100 units/mL formulation available without PA.

Section XIV. Please complete for Humulin N requests.

Has the member had an inadequate response or adverse reaction to Novolin N?

☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XXV below.* ☐ No

Section XV. Please complete for Novolin 70/30 requests.

Has the member had a trial with Humulin 70/30 (insulin NPH/regular insulin 70/30)?

☐ Yes. Please list the drug name, dates/duration of use, and outcomes in Section XXV below.* ☐ No

Section XVI. Please complete for metformin extended-release, gastric tablet (generic Glumetza), and metformin extended-release, osmotic tablet requests.

1. Please attach medical records documenting an inadequate response (defined as ≥ 90 days of therapy) or adverse reaction, at the requested dose, to the metformin extended-release, XR tablet formulation available without prior authorization.
2. For metformin extended-release, gastric tablet (generic Glumetza), please provide medical necessity for the use of the requested product instead of other metformin formulations available without prior authorization.

Section XVII. Please complete for metformin immediate-release solution and Riomet ER requests.

1. Is there a medical necessity for the liquid formulation?
   ☐ Yes. Please explain.
   ☐ No. Please attach medical records documenting an inadequate response (defined as ≥ 90 days of therapy), allergic reaction, or adverse reaction to metformin tablets.
2. For Riomet ER, please attach medical records documenting an inadequate response (defined as ≥ 90 days of therapy) to metformin immediate-release solution formulation.

Section XVIII. Please complete for metformin immediate-release 625 mg and 750 mg tablet requests.

Please provide medical necessity for the requested formulation instead of metformin tablets available without prior authorization.

Section XIX. Please complete for miglitol requests.

1. Has the member tried metformin used in combination with acarbose?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XXV below.* ☐No

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2. If the answer to question 1 is no, has the member tried metformin?
   ☐ Yes. Please list the drug name, dates/duration of use, and outcome in Section XXV below.* ☐ No
3. If the answer to question 1 is no, has the member tried acarbose?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XXV below.*
   ☐ No. Please describe if there is a contraindication to acarbose.
4. If the request is for greater than three tablets per day, please complete Section XXIV below.

Section XX. Please complete for Inpefa requests.

1. For an indication of reduction of risk of cardiovascular death, hospitalization for heart failure, and urgent heart failure visit, has the member tried or does the member have a contraindication to both dapagliflozin and Jardiance?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XXV below.* ☐ No
2. For an indication of reduction of risk of cardiovascular death, hospitalization for heart failure, and urgent heart failure visit in type 2 diabetes mellitus and chronic kidney disease with other cardiovascular risk factors, has the member tried two or does the member have a contraindication to all of the following: dapagliflozin, Invokana, Jardiance?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcome in Section XXV below.* ☐ No
3. If the request is for greater than one tablet per day, please complete Section XXIV below.

Section XXI. Please complete for glipizide 2.5 mg tablet requests.

Please provide medical necessity for the requested formulation instead of glipizide tablets available without prior authorization.

Section XXII. Please complete for Brynovin solution requests.

1. Is there a medical necessity for the liquid formulation?
   ☐ Yes. Please explain.
   ☐ No. Please attach medical records documenting an inadequate response, allergic reaction, or adverse reaction to sitagliptin tablets.
2. If the request is for quantities exceeding the quantity limit, please complete Section XXIV below.

Section XXIII. Please complete for requests for Januvia.

1. Has the member tried metformin used in combination with Tradjenta?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XXV below.* ☐ No
2. If the answer to question 1 is no, has the member tried metformin?
   ☐ Yes. Please list the drug name, dates/duration of use, and outcome in Section XXV below.* ☐ No
3. If the answer to question 1 is no, has the member tried Tradjenta?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XXV below.*
   ☐ No. Please describe if there is a contraindication to Tradjenta.
4. If the request is for greater than one tablet per day, please complete Section XXIV below.

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

Please describe the clinical rationale for exceeding the quantity limit or why dose cannot be consolidated.

Section XXV. Please complete for all requests as needed.

Please provide the following information regarding previous trials.*

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, contraindication, or other.

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, contraindication, or other.

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, contraindication, or other.

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, contraindication, or other.

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, contraindication, or other.

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

Section XXVI. 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. ______

Section XXVII. Please complete for recertification requests for GLP-1 and GIP/GLP-1 agonists.

1. Member's most recent hemoglobin A1C ______ Date ______

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2. Has the member had a reduction in A1C since initiation of the requested agent? ☐ Yes ☐ No
   Please describe. If no, include treatment plan addressing escalation of therapy for A1C reduction.

Section XXVIII. 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* First name* MI

NPI* Individual MH Provider ID

DEA No. Office Contact Name

Address City State Zip

E-mail address

Telephone No.*

Fax No.* (Please provide fax number for PA response notification.)

** Required*

Please also complete for professionally administered medications, if applicable.

Start date End date

Servicing prescriber/facility name ☐ Same as prescribing provider

Servicing provider/facility address

Servicing provider NPI/tax ID No.

Name of billing provider

Billing provider NPI No.

Is this a request for recertification? ☐ Yes ☐ No

CPT code No. of visits J code No. of units

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

Date

(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.)