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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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Non-Diabetic GIP/GLP-1 and GLP-1 Receptor Agonists 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

- ☐ Wegovy (semaglutide injection)
- ☐ Wegovy (semaglutide tablet)
- ☐ Zepbound (tirzepatide)
- ☐ Other

Dose and frequency of medication requested

Indication or ICD-10 code, if applicable

- ☐ Risk reduction of major adverse cardiovascular events (MACE) with established cardiovascular disease and obesity or overweight
- ☐ Moderate to severe obstructive sleep apnea (OSA) with obesity
- ☐ Nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis
- ☐ Metabolic dysfunction-associated steatohepatitis (MASH) with moderate to advanced liver fibrosis
- ☐ Other

Section I. Please complete for all requests.

1. Member's baseline BMI ____ kg/m^2 Date ____
2. Member's current BMI ____ kg/m^2 Date ____
3. Has the member been counseled to continue reduced-calorie diet and increased physical activity?
   ☐ Yes ☐ No
4. Will the requested agent be used in combination with another GLP-1 receptor agonist? ☐ Yes ☐ No
5. Is the prescriber a specialist in the treatment of the requested indication?
   ☐ Yes. Please indicate prescriber specialty.
   ☐ No. Please attach consultation notes from a specialist in the treatment of the requested indication (e.g., gastroenterologist, hepatologist, neurologist, sleep specialist, or other specialist in the treatment of OSA).

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

1. Please provide medical records from liver biopsy performed within the past three years or noninvasive testing (NIT) performed within the last 12 months 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. Please provide start date
   ☐ No
   If no, did the member have an inadequate response to Rezdiffra monotherapy for at least one year and Wegovy monotherapy at maximally tolerated dose 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 monotherapy trial at maximally tolerated dose

Section III. Please also complete for indication of risk reduction of major adverse cardiovascular events (MACE) for Wegovy requests.

Please attach medical records documenting one of the following: history of myocardial infarction, history of stroke (ischemic or hemorrhagic), symptomatic peripheral arterial disease (e.g., intermittent claudication with ankle–brachial index <0.85, peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease).

Section IV. Please also complete for the treatment of moderate to severe obstructive sleep apnea (OSA) in adults with obesity.

1. Please provide medical records documenting an apnea-hypopnea index (AHI) of at least 15 events per hour based on polysomnogram (PSG) confirming diagnosis of moderate to severe OSA.
2. Does the member also have a diagnosis of type 2 diabetes mellitus? ☐ Yes ☐ No
3. For Zepbound, does the member also have a diagnosis of prediabetes? ☐ Yes ☐ No
4. For Zepbound, has the member had a trial for at least three months with one of the following breathing devices within the past year: Auto-adjusting positive airway pressure (APAP), Bilevel positive airway pressure (BiPAP), Constant positive airway pressure (CPAP) therapy?
   ☐ Yes. Please complete the following.
   ☐ APAP ☐ BiPAP ☐ CPAP
   Dates/duration of use Outcome
   ☐ No. Please describe why APAP, BiPAP, and CPAP are not appropriate for this member.
5. For Zepbound, please attach medical records documenting an inadequate response (at maximally tolerated dose for six months), adverse reaction (allergic in nature or cannot be expected or managed as part of GLP-1 therapy) or contraindication to semaglutide.

Section V. Please complete for recertification requests.

1. For the indication of risk reduction of MACE, does the member require use of Wegovy for cardiovascular risk reduction and the benefit of cardiovascular risk reduction outweighs the risk associated with use of GLP-1 agents?
   ☐ Yes, please explain.
   ☐ No

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2. For the indication of OSA, 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, or reduction in CPAP settings?

   ☐ Yes. Please describe.

   ☐ No

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

Section VI. 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 VII. 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

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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.)