



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
 P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Glaucoma 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.

Member information

Last name _____ First name _____ MI _____
 MassHealth member ID # _____ Date of birth _____
 Gender (Check one.) F M Member's place of residence home nursing facility

Medication information

Medication requested

- | | |
|--|--|
| <input type="checkbox"/> bimatoprost 0.03% | <input type="checkbox"/> timolol ophthalmic gel forming solution |
| <input type="checkbox"/> dorzolamide/timolol preservative free | <input type="checkbox"/> timolol ophthalmic unit dose solution |
| <input type="checkbox"/> Durysta (bimatoprost implant) | <input type="checkbox"/> Vyzulta (latanoprostene) |
| <input type="checkbox"/> Rhopressa (netarsudil) | <input type="checkbox"/> Xelpros (latanoprost emulsion) |
| <input type="checkbox"/> Rocklatan (netarsudil/latanoprost) | <input type="checkbox"/> Zioptan (tafluprost) |
| <input type="checkbox"/> Simbrinza (brinzolamide/brimonidine) | |

Indication (Check all that apply.)

- Open-angle glaucoma Ocular hypertension Other _____

Dose, frequency, and duration of medication requested _____

Section I. Please complete for timolol ophthalmic gel forming solution and timolol ophthalmic unit dose solution requests.

Has the member had a trial with an ophthalmic timolol formulation that is available without PA?

- Yes No. Please provide clinical rationale for not using an ophthalmic timolol formulation that is available without PA. _____

Section II. Please complete for bimatoprost 0.03% and Durysta requests.

- Has the member had a trial with Lumigan?
 Yes No. Please provide clinical rationale for not using Lumigan. _____
- For Durysta, if you answered "No" to the question above, does the member have a medical necessity for an implantable formulation instead of eye drops? _____
- For Durysta, please specify affected eye. Left eye Right eye

4. For Durysta, is the request for retreatment of the same eye? Yes No

Section III. Please complete for dorzolamide/timolol preservative free and Xelpros requests.

Has the member experienced sensitivity to benzalkonium chloride or any other preservatives used in ophthalmic preparations?

Yes No. Please provide clinical rationale for the use of the requested formulation instead of the respective formulation that is available without PA. _____

Section IV. Please complete for Rhopressa and Rocklatan requests.

1. Has the member had a trial of combination therapy with a prostaglandin analog and an ophthalmic beta-blocker?

Yes. Please list the drug names, dates/duration of use and outcomes below.*

No. Please provide clinical rationale for not using combination therapy with a prostaglandin analog and an ophthalmic beta-blocker. _____

2. Does the member have a contraindication to ophthalmic beta-blockers?

Yes. Please describe. _____ No

If yes, has the member had a trial of combination therapy with a prostaglandin analog and either an ophthalmic alpha-2 adrenergic agonist, parasymphomimetic, or carbonic anhydrase inhibitor?

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

3. For Rhopressa, does the member have a contraindication to prostaglandin analogs?

Yes. Please describe. _____ No

If yes, has the member had a trial of combination therapy with an ophthalmic beta-blocker and either an ophthalmic alpha-2 adrenergic agonist, parasymphomimetic, or carbonic anhydrase inhibitor?

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

Please provide details for the previous trials.

Drug _____ Dates/duration _____ Adverse reaction Inadequate response Other

Briefly describe details of adverse reaction, inadequate response, or other.

Drug _____ Dates/duration _____ Adverse reaction Inadequate response Other

Briefly describe details of adverse reaction, inadequate response, or other.

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

Section V. Please complete for Simbrinza requests.

Has the member had a trial with a carbonic anhydrase inhibitor and an ophthalmic brimonidine product?

Yes No. Please provide clinical rationale for not using a carbonic anhydrase inhibitor and an ophthalmic brimonidine product. _____

Section VI. Please complete for Vyzulta requests.

Has the member had a trial of combination therapy with latanoprost solution and an ophthalmic beta-blocker?

Yes No. Please provide clinical rationale for not using combination therapy with latanoprost solution and an ophthalmic beta-blocker. _____

Section VII. Please complete for Zioptan requests.

1. Has the member had a trial with latanoprost solution?

Yes No. Please provide clinical rationale for not using latanoprost solution. _____

2. Has the member had a trial with Xelpros?

Yes No. Please provide clinical rationale for not using Xelpros. _____

Section VIII. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

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.* _____

* Required

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my 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.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____