



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

## Diabetes Medical Supplies and Emergency Treatments 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](http://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

### Product information

#### Device requested

- Dexcom G6
  - Receiver
  - Sensor
  - Transmitter
- Freestyle Libre 14 Day
  - Reader
  - Sensor
- Freestyle Libre 2
  - Reader
  - Sensor
- Omnipod
  - Omnipod Personal Diabetes Manager
  - Omnipod Pod Pack
- Omnipod Dash
  - Omnipod Dash Personal Diabetes Manager
  - Omnipod Dash Pod Pack
- V-Go

#### Medication requested

- Gvoke (glucagon auto-injection, prefilled syringe)
- Zegalogue (dasiglucagon)

#### Non-drug product requested      Qty/month

- Blood glucose testing strips > 100 units/month
  - Freestyle \_\_\_\_\_
  - Freestyle Insulinx \_\_\_\_\_
  - Freestyle Lite \_\_\_\_\_
  - Precision Xtra \_\_\_\_\_
- Non-preferred blood glucose testing strips  
 (Please specify brand, e.g. Freestyle Neo, etc.)  
 \_\_\_\_\_

**Dose, frequency, and duration of medication or medical supplies requested** \_\_\_\_\_

#### Indication (Check all that apply.)

- 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.

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

1. Is the member stabilized on the requested device?  Yes. Please provide start date. \_\_\_\_\_  No
  2. Does the current treatment plan involve testing blood glucose at least four times per day?  Yes  No
  3. Is the member currently receiving multiple daily insulin injections?  Yes  No
  4. Is the member currently using an insulin pump?  Yes  No
  5. Does the member exhibit any of the following clinical characteristics? (Check all that apply.)
    - Yes
      - An A1c  $\geq 7\%$ , or does not meet documented target treatment despite diabetic education and adherence to self-monitoring of glucose levels
      - 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 or hypoglycemia
      - Use of a compatible insulin pump to achieve glycemic control
      - Pregnancy
    - No. Please explain why the member is a candidate for continuous blood glucose monitoring.
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**Section II. Please complete for Omnipod, Omnipod Dash, and V-Go requests.**

1. Is the member stabilized on the requested device?  Yes. Please provide start date. \_\_\_\_\_  No
  2. Does the current treatment plan involve testing blood glucose at least four times per day?  Yes  No
  3. Is the member currently receiving three or more daily insulin injections?  Yes  No
  4. Is the member currently using an insulin pump?  Yes  No
  4. Does the member have an A1c  $>7\%$ , or does not meet documented target treatment?  Yes  No
  5. Does the member exhibit any of the following clinical characteristics? (Check all that apply.)
    - Yes
      - Frequent hypoglycemia
      - Fluctuations of more than 100 mg/dL in blood glucose before mealtime
      - Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL
      - History of severe glycemic excursions
    - No. Please explain why the member is a candidate for continuous subcutaneous insulin infusion.
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**Section III. Please complete for Dexcom G6, Freestyle Libre 14 Day, Freestyle Libre 2, Omnipod, Omnipod Dash, and V-Go recertification requests.**

For Omnipod, Omnipod Dash, and V-Go, only question 1 is 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. \_\_\_\_\_
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**Section IV. Please complete for Gvoke and Zegalogue requests.**

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

- Yes
  - No. Please describe why not. \_\_\_\_\_
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**Section V. Please complete for Freestyle Neo requests.**

Will the member be using a compatible continuous glucose monitoring device (i.e., Freestyle Libre 2, Freestyle Libre 14 Day)?

Yes

No. Please provide medical necessity for use of Freestyle Neo. \_\_\_\_\_

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**Section VI. Please complete for all requests exceeding the quantity limit.**

1. Is the member utilizing a continuous glucose monitoring device?  Yes  No

2. Please provide medical necessity for exceeding the quantity limit. If applicable, please include a treatment plan describing self-testing frequency.

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**Section VII. Please complete for all requests for non-preferred products if one or more preferred products have been designated for this class.**

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

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**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

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**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 \_\_\_\_\_