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

Print Clear

Injectable Antibiotic 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

☐ Avycaz (ceftazidime/avibactam)
☐ Baxdela (delafloxacin injection)
☐ Dalvance (dalbavancin)
☐ Fetroja (cefiderocol)
☐ Kimyrsa (oritavancin)
☐ linezolid injection
☐ Nuzyra (omadacycline injection)
☐ Orbactiv (oritavancin)
☐ Recarbrio (imipenem/cilastatin/relebactam)
☐ Sivextro (tedizolid injection)
☐ Synercid (quinupristin/dalfopristin)
☐ tigecycline
☐ Vabomere (meropenem/vaborbactam)
☐ Vibativ (telavancin)
☐ Xenleta (lefamulin injection)
☐ Xerava (eravacycline)
☐ Zemdri (plazomicin)
☐ Zerbaxa (ceftolozane/tazobactam)

Drug Code (if applicable) _____

Dose, frequency, and duration of medication requested _____

☐ Initial request ☐ Recertification request ☐ Naïve to therapy ☐ Continuation of therapy

Is the member stabilized on the requested medication? ☐ Yes. Dates of use _____ ☐ No

Indication (Check all that apply.)

☐ Bacteremia
☐ Bone or joint infection: _____
☐ Central nervous system (CNS) infection: _____
☐ Community-acquired bacterial pneumonia (CABP)
☐ Complicated intra-abdominal infection (cIAI)
☐ Complicated urinary tract infection (cUTI)
☐ Endocarditis
☐ Hospital-acquired (nosocomial) bacterial pneumonia (HABP)
☐ Skin and soft tissue infection (SSTI):
  ☐ Acute ☐ Complicated ☐ Uncomplicated
☐ Ventilator-associated bacterial pneumonia
☐ Other infection: _____

Please indicate the infecting organism.

☐ Methicillin-resistant Staphylococcus aureus (MRSA)
  ☐ Confirmed ☐ Suspected
☐ Vancomycin-resistant Enterococcus (VRE)
☐ Non-MRSA/non-VRE: _____
  ☐ Confirmed ☐ Suspected

Section I. Please complete for all requests.

1. Were cultures and susceptibility testing performed?
   ☐ Yes. Please attach a copy of the culture and sensitivity report with submission.
   ☐ No. Please provide clinical rationale why cultures and susceptibility testing were not performed.
   _____
2. Please list previous antibiotic trials for the requested indication including outcomes.*
   Drug _____ Outcome _____ Dates of use _____
   Drug _____ Outcome _____ Dates of use _____
   Drug _____ Outcome _____ Dates of use _____
3. Is the member ≥ 18 years of age? ☐ Yes ☐ No
4. For requests for Avycaz and Zerbaxa for a diagnosis of complicated intra-abdominal infection (cIAI), will the member be using the requested medication concurrently with metronidazole?
   ☐ Yes
   ☐ No. Please explain. _____
5. For requests for Kimyrsa, please describe medical necessity for use instead of Orbactiv.
   _____

**Attach a letter with additional information regarding medication trials as applicable.*

Section II. 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 _____