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

Oral Antibiotics and Anti-Infectives 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

- ☐ amoxicillin/clavulanate extended-release
- ☐ Augmentin (amoxicillin/clavulanate 125/31.25 mg/5 mL suspension)
- ☐ azithromycin powder packet
- ☐ Baxdela (delafloxacin tablet)
- ☐ cefaclor extended-release
- ☐ cefadroxil tablet
- ☐ cefixime
- ☐ cefpodoxime suspension
- ☐ cephalexin 750 mg capsule
- ☐ ciprofloxacin 100 mg tablet
- ☐ clarithromycin extended-release
- ☐ Coartem (artemether/lumefantrine) > 24 units/365 days
- ☐ Dificid (fidaxomicin)
- ☐ Doryx (doxycycline hyclate delayed-release 120 mg tablet)
- ☐ doxycycline hyclate 50 mg tablet
- ☐ doxycycline hyclate 75 mg, 150 mg tablet
- ☐ doxycycline hyclate delayed-release 50 mg, 75 mg, 80 mg, 100 mg, 150 mg, 200 mg tablet
- ☐ doxycycline monohydrate 40 mg capsule
- ☐ doxycycline monohydrate 75 mg capsule
- ☐ doxycycline monohydrate 150 mg capsule
- ☐ doxycycline monohydrate 150 mg tablet
- ☐ Egaten (triclabendazole)
- ☐ Krintafel (tafenoquine) > 2 units/365 days
- ☐ Lampit (nifurtimox)
- ☐ linezolid suspension
- ☐ mebendazole
- ☐ metronidazole 375 mg capsule
- ☐ minocycline extended-release 45 mg, 90 mg, 135 mg tablet
- ☐ minocycline tablet
- ☐ Minolira (minocycline extended-release 105 mg, 135 mg tablet)
- ☐ nitazoxanide tablet
- ☐ nitrofurantoin suspension
- ☐ Nuzyra (omadacycline tablet)
- ☐ ofloxacin tablet
- ☐ pyrimethamine
- ☐ quinine
- ☐ Sivextro (tedizolid tablet)
- ☐ Solosec (secnidazole)
- ☐ tinidazole
- ☐ Xenleta (lefamulin tablet)
- ☐ Xifaxan (rifaximin 550 mg)
- ☐ Ximino (minocycline extended-release capsule

Dose, frequency, and duration of medication requested _____

Indication _____

Section I. Please complete for all requests.

1. Is the member under the care of an Infectious Disease specialist? ☐ Yes ☐ No
2. Please list previous trials for the requested indication including outcomes.*

   Drug _____ Outcome _____ Dates of use _____
   Drug _____ Outcome _____ Dates of use _____
   Drug _____ Outcome _____ Dates of use _____

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

Section II. Please complete for all requests for antibiotics.

1. Please indicate the infecting organism.
   - ☐ Clostridium difficile
   - ☐ Methicillin-resistant Staphylococcus aureus (MRSA)
   - ☐ Vancomycin-resistant Enterococcus (VRE)
   - ☐ Other _____
2. Is the infecting organism confirmed or suspected? ☐ Confirmed ☐ Suspected
3. 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.

     _____

Section III. Please also complete for requests for amoxicillin/clavulanate extended-release, cefaclor extended-release, and clarithromycin extended-release.

Please describe the medical necessity for the use of an extended-release dosage form over immediate-release formulations of the requested agent. Please describe prior trials and outcomes with the immediate-release formulation and additional antibiotics, if applicable, in Section I above.

_____

Section IV. Please also complete for requests for azithromycin powder packet, cefadroxil tablet, cefpodoxime suspension, cephalexin 750 mg capsule, ciprofloxacin 100 mg tablet, and metronidazole 375 mg.

Please describe prior trials and outcomes with formulations of the requested antibiotic that are available without PA in Section I above. Please describe medical necessity for the use of the requested antibiotic over alternative strengths that do not require a PA.

_____

Section V. Please also complete for requests for doxycycline agents requiring PA.

Please describe prior trials and outcomes with doxycycline formulations that are available without PA in Section I above. Please provide clinical rationale for the requested formulation.

_____

Section VI. Please also complete for requests for cefixime.

Is the member completing a course of therapy that was initiated in the hospital? ☐ Yes ☐ No

If the answer to the above question is no, has the member had a trial with cefdinir or cefpodoxime?

☐ Yes. Please describe prior trials and outcomes in Section I above.

☐ No. Please explain why not. _____

Section VII. Please also complete for requests for Xifaxan 550 mg.

1. For the diagnosis of hepatic encephalopathy, has the member tried lactulose?
   - ☐ Yes. Please describe prior trials and outcomes in Section I above.
   - ☐ No. Please explain why not. _____

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2. For the diagnosis of irritable bowel syndrome with diarrhea, has the member had a trial with three of the following: loperamide, diphenoxylate/atropine, bile acid sequestrant, bismuth subsalicylate, bulk-forming agent, tricyclic antidepressant (TCA)?
   ☐ Yes. Please describe prior trials and outcomes in Section I above.
   ☐ No. Please explain why not. _____

Section VIII. Please also complete for requests for Sivextro tablet.

1. For Sivextro for the diagnosis of VRE, has the member had a trial with linezolid?
   ☐ Yes. Please describe prior trials and outcomes in Section I above.
   ☐ No. Please explain why not. _____
2. For the diagnosis of MRSA, has the member had a trial with clindamycin, doxycycline or minocycline, sulfamethoxazole/trimethoprim, or vancomycin IV?
   ☐ Yes. Please describe prior trials and outcomes in Section I above.
   ☐ No. Please explain why not. _____

Section IX. Please also complete for requests for minocycline extended-release 45 mg, 90 mg, 135 mg tablets, minocycline tablets, Minolira, and Ximino.

1. For minocycline immediate-release tablet, please describe prior trials and outcomes with minocycline capsules in Section I above. Please describe clinical rationale for the dosage form over immediate-release capsules. _____
2. For minocycline extended-release tablet and capsule formulations, has the member had a trial with minocycline capsules and Solodyn?
   ☐ Yes. Please describe prior trials and outcomes in Section I above.
   ☐ No. Please explain why not. _____

Section X. Please also complete for requests for Dificid suspension, linezolid suspension, and nitrofurantoin suspension.

Please describe medical necessity for use of the suspension formulation instead of the respective capsule or tablet formulation.

_____

Section XI. Please also complete for Augmentin 125/31.25 mg/5 mL suspension requests.

Please provide clinical rationale for not using 250/62.5 mg/5 mL formulation.

_____

Section XII. Please also complete for requests for Baxdela tablet and Nuzyra tablet.

1. For suspected or confirmed MRSA infections or mixed pathogen infections (including MRSA), has the member had a trial with clindamycin, doxycycline or minocycline, linezolid, sulfamethoxazole/trimethoprim, or vancomycin IV?
   ☐ Yes. Please describe prior trials and outcomes in Section I above.
   ☐ No. Please explain why not. _____
2. For suspected or confirmed mixed pathogen infections (including MRSA), has the member had a trial with at least one other antibiotic with gram-negative coverage available without PA?
   ☐ Yes. Please describe prior trials and outcomes in Section I above.
   ☐ No. Please explain why not. _____

Section XIII. Please also complete for requests for ofloxacin tablet.

Has the member had a trial with ciprofloxacin or levofloxacin?

☐ Yes. Please describe prior trials and outcomes in Section I above.

☐ No. Please explain why not. _____

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Section XIV. Please also complete for requests for Coartem > 24 units/365 days and Krintafel (tafenoquine) > two units/365 days.

1. Please describe the medical necessity for exceeding the quantity limit.

   _____

2. For Krintafel, is the member currently receiving chloroquine therapy?
   ☐ Yes.
   ☐ No. Please explain why not. _____

Section XV. Please also complete for requests for Lampit.

Member's current weight _____ Date _____

Section XVI. 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 _____