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

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**.

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 5
  - ☐ Omnipod 5 Pod Pack
- ☐ Omnipod Classic
  - ☐ Omnipod Classic Personal Diabetes Manager
  - ☐ Omnipod Classic 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.

_____

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. Is the member currently receiving multiple daily insulin administrations? ☐ Yes ☐ No
3. Is the member currently using an insulin pump? ☐ Yes ☐ No
4. Does the member exhibit any of the following clinical characteristics? (Check all that apply.)

☐ Yes
- ☐ An A1c ≥7%, or does not meet documented target treatment goal
- ☐ 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 continuos blood glucose monitoring.

_____

Section II. Please complete for Omnipod 5, Omnipod Classic, 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 continuos subcutaneous inulin infusion.

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Section III. Please complete for Dexcom G6, Freestyle Libre 14 Day, Freestyle Libre 2, Omnipod 5, Omnipod Classic, Omnipod Dash, and V-Go recertification requests.

For Omnipod 5, Omnipod Classic, 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 a trial with Baqsimi?

☐ Yes. Please list the dates/duration of trials and outcomes below.

Dates/duration of use _____

Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

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

_____

☐ No. Please describe why Baqsimi is not appropriate for this member. _____

_____

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. _____

_____

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.

_____

_____

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 _____