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

Antidiabetic 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 (Check one or all that apply. Where applicable, the brand name is provided in brackets for reference.)

Single Injectable Agents

- ☐ Adlyxin (lixisenatide)
- ☐ Bydureon Bcise (exenatide extended-release auto-injection)
- ☐ Ozempic (semaglutide injection)

Single Oral Agents

- ☐ alogliptin
- ☐ metformin extended-release, osmotic tablet [Fortamet]
- ☐ metformin extended-release, gastric tablet [Glumetza]
- ☐ metformin immediate-release solution ≥ 13 years of age
- ☐ miglitol
- ☐ Mounjaro (tirzepatide)
- ☐ Riomet ER (metformin extended-release suspension)
- ☐ Rybelsus (semaglutide tablet)
- ☐ Steglatro (ertugliflozin)

Combination Injectable Agents

- ☐ Soliqua (insulin glargine/lixisenatide)
- ☐ Xultophy (insulin degludec/liraglutide)

Insulin Agents

- ☐ Admelog (insulin lispro)
- ☐ Afrezza (insulin human inhalation powder)
- ☐ Basaglar (insulin glargine)
- ☐ Fiasp (insulin aspart)
- ☐ Humulin N (insulin NPH)
- ☐ Lyumjev (insulin lispro-aabc)
- ☐ Semglee (insulin glargine)

Combination Oral Agents

- ☐ alogliptin/metformin
- ☐ alogliptin/pioglitazone
- ☐ Glyxambi (empagliflozin/linagliptin)
- ☐ pioglitazone/glimepiride
- ☐ Qtern (dapagliflozin/saxagliptin)
- ☐ repaglinide/metformin
- ☐ Segluromet (ertugliflozin/metformin)
- ☐ Steglujan (ertugliflozin/sitagliptin)
- ☐ Trijardy XR (empagliflozin/linagliptin/metformin extended-release)

Other Medication

- ☐ Other* _____

**If request is for a non-preferred brand name or generic product, please attach supporting documentation (e.g., copies of medical records and/or office notes regarding adverse reaction or inadequate response to the preferred product).*

Dose and frequency of medication 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 _____

Please list all other antidiabetic medications currently prescribed for the member for this indication.

Drug _____ Dose and Frequency _____ Dates of use _____
Drug _____ Dose and Frequency _____ Dates of use _____
Drug _____ Dose and Frequency _____ Dates of use _____

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 combination oral agents.

1. Has the member tried metformin used in combination with at least one of the non-metformin agents in the requested combination?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XIII below.* ☐ No
2. If the answer to question 1 is no, has the member tried metformin?
   ☐ Yes. Please list the drug name, dates/duration of use, and outcome in Section XIII below.* ☐ No
3. If the answer to question 1 is no, has the member tried at least one of the non-metformin agents in the requested combination?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XIII below.* ☐ No
4. If the request is for Trijardy XR, please provide a clinical rationale for use instead of the commercially-available separate agents. _____

Section II. Please complete for single and combination injectable agents and Rybelsus.

1. Has the member tried metformin used in combination with Bydureon, Byetta, Trulicity, or Victoza?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XIII below.* ☐ No
2. If the answer to question 1 is no, has the member tried metformin?
   ☐ Yes. Please list the drug name, dates/duration of use, and outcome in Section XIII below.* ☐ No
3. If the answer to question 1 is no, has the member tried Bydureon, Byetta, Trulicity, or Victoza?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XIII below.*
   ☐ No. Please describe if there is a contraindication to Bydureon, Byetta, Trulicity, and Victoza.
   _____
4. If the request is for quantities exceeding the quantity limit, please complete Section XIII below.
5. If the request is for Mounjaro, will the requested agent be used in combination with a GLP-1 receptor agonist? ☐ Yes ☐ No
   If yes, please provide clinical rationale for concurrent use with a GLP-1 receptor agonist. _____
   _____

Section III. Please complete for alogliptin.

1. Has the member tried metformin used in combination with Januvia, Onglyza, or Tradjenta?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XIII below.* ☐ No
2. If the answer to question 1 is no, has the member tried metformin?
   ☐ Yes. Please list the drug name, dates/duration of use, and outcome in Section XIII below.* ☐ No

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3. If the answer to question 1 is no, has the member tried Januvia, Onglyza, or Tradjenta?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XIII below.*
   ☐ No. Please describe if there is a contraindication to Januvia, Onglyza, and Tradjenta.

   _____

4. If the request is for greater than one tablet per day, please complete Section XII below.

Section IV. Please complete for Steglatro.

1. Has the member tried metformin used in combination with Farxiga, Invokana, or Jardiance?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XIII below.* ☐ No
2. If the answer to question 1 is no, has the member tried metformin?
   ☐ Yes. Please list the drug name, dates/duration of use, and outcome in Section XIII below.* ☐ No
3. If the answer to question 1 is no, has the member tried Farxiga, Invokana, or Jardiance?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XIII below.*
   ☐ No. Please describe if there is a contraindication to Farxiga, Invokana, and Jardiance.

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4. If the request is for greater than one tablet per day, please complete Section XII below.

Section V. Please complete for requests for Basaglar or Semglee.

Has the member had an inadequate response or adverse reaction to Lantus Solostar prefilled syringe or Lantus vial?
☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XIII below.* ☐ No

Section VI. Please complete for requests for Admelog, Fiasp, or Lyumjev.

Has the member had an inadequate response or adverse reaction to Apidra, Humalog, or insulin aspart (generic Novolog)?
☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XIII below.* ☐ No

Section VII. Please complete for requests for Afrezza.

Does the member have a medical necessity for the use of an inhaled insulin product over an injectable or prefilled insulin syringe?
☐ Yes. Please describe. _____
☐ No

Section VIII. Please complete for requests for Humulin N.

Has the member had an inadequate response or adverse reaction to Novolin N?
☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XIII below.* ☐ No

Section IX. Please complete for requests for metformin extended-release (generic Fortamet and Glumetza).

1. Please attach medical records documenting an inadequate response despite 90 days of therapy or adverse reaction, at the requested dose, to the metformin extended-release, XR tablet formulation available without prior authorization.
2. For metformin extended-release, gastric tablet (generic Glumetza), please provide clinical rationale for the use of the requested product instead of other metformin formulations available without prior authorization.

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Section X. Please complete for requests for metformin immediate-release solution and Riomet ER.

1. Is there a medical necessity for the liquid formulation?
   ☐ Yes. Please explain. ______________________________
   ☐ No. Please attach medical records documenting an inadequate response despite 90 days of therapy, allergic reaction, or adverse reaction to metformin tablets.
2. For Riomet ER, please attach medical records documenting an inadequate response despite 90 days of therapy with the immediate-release metformin solution formulation.

Section XI. Please complete for requests for miglitol.

1. Has the member tried metformin used in combination with acarbose?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XIII below.* ☐ No
2. If the answer to question 1 is no, has the member tried metformin?
   ☐ Yes. Please list the drug name, dates/duration of use, and outcome in Section XIII below.* ☐ No
3. If the answer to question 1 is no, has the member tried acarbose?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XIII below.*
   ☐ No. Please describe if there is a contraindication to acarbose.
   ____
4. If the request is for greater than three tablets per day, please complete Section XII below.

Section XII. Please complete for requests for quantities above quantity limits.

Please describe the clinical rationale for exceeding the quantity limit.

____

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Section XIII. Please complete for all requests as needed.

Please provide the following information regarding previous trials.*

Drug name ______________________ 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.
____

Drug name ______________________ 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.
____

Drug name ______________________ 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.
____

Drug name ______________________ 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.
____

Drug name ______________________ 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.
____

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

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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*

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 _____