Print Clear

Prior Authorization Request Administrative Information

Member Information

Last name _____ First name _____ MI _____

Member ID _____ Date of birth _____

Sex assigned at birth ☐ Female ☐ Male ☐ "X" or Intersex

Current gender ☐ Female ☐ Male ☐ Transgender male ☐ Transgender female ☐ Other _____

Place of residence ☐ Home ☐ Nursing facility ☐ Other _____

Race/ethnicity _____ Preferred spoken language _____ Preferred written language _____

MassHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, creed, sexual orientation, or sex (including gender identity and gender stereotyping).

Plan Contact Information

Please indicate the member's MassHealth Plan and fax or submit this completed and signed form according to the Plan's contact information below.

MassHealth Fee-For-Service (FFS) Plan, Primary Care Clinician (PCC) Plan, Primary Care Accountable Care Organization (PCACO) Plan, Children's Medical Security Plan, and Health Safety Net Plan
☐ **MassHealth Drug Utilization Review Program** Pharmacy: Fax: (877) 208-7428 - Tel: (800) 745-7318
MassHealth Managed Care Organization (MCO) and Accountable Care Partnership Plans (ACPP)
☐ **Fallon Health** Online Prior Authorization: go.covermymeds.com/OptumRx Online Prior Authorization: providerportal.surescripts.net/ProviderPortal/optum Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033
☐ **Health New England** Online Prior Authorization: go.covermymeds.com/OptumRx Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545
☐ **Mass General Brigham Health Plan** Online Prior Authorization (Non-Specialty Drugs): go.covermymeds.com/OptumRx Online Prior Authorization (Specialty/Medical Drugs): provider.massgeneralbrighamhealthplan.org Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555
☐ **Tufts Health Plan** Online Prior Authorization: point32health.promptpa.com Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985
☐ **WellSense Health Plan** Online Prior Authorization: wellsense.org/providers/ma/pharmacy/prior-authorizations Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822

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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.**

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)
- ☐ Byetta (exenatide 5 mcg) > 1.2 mL/30 days
- ☐ Byetta (exenatide 10 mcg) > 2.4 mL/30 days
- ☐ Mounjaro (tirzepatide)
- ☐ Ozempic (semaglutide injection)
- ☐ Trulicity (dulaglutide) > 2 mL/28 days
- ☐ Tzield (teplizumab-mzwv)
- ☐ Victoza (liraglutide) > 9 mL/30 days

Single Oral Agents

- ☐ alogliptin
- ☐ Inpefa (sotagliflozin)
- ☐ metformin extended-release, gastric tablet [Glumetza]
- ☐ metformin extended-release, osmotic tablet
- ☐ metformin immediate-release 625 mg tablet
- ☐ metformin immediate-release solution ≥ 13 years of age
- ☐ miglitol
- ☐ 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)
- ☐ Basaglar Tempo (insulin glargine)
- ☐ Fiasp (insulin aspart)
- ☐ Humalog Tempo (insulin lispro)
- ☐ Humulin N (insulin NPH)
- ☐ insulin glargine-yfgn
- ☐ Lyumjev (insulin lispro-aabc)
- ☐ Lyumjev Tempo (insulin lispro-aabc)
- ☐ Rezvoglar (insulin glargine-aglr)

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 or include ICD-10 code, if applicable.)

☐ Type 1 Diabetes Mellitus ☐ Type 2 Diabetes Mellitus

☐ Stage _____ What is the member's most recent hemoglobin A1C? _____ Date _____

☐ Reduction of risk of cardiovascular death, hospitalization for heart failure, and urgent heart failure visit

☐ Cardiovascular risk factors _____

☐ Chronic kidney disease

☐ Other _____

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 XVII 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 XVII 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 XVII below.* ☐ No
4. For Trijardy XR, please provide medical necessity for use instead of the commercially-available separate agents. _____

Section II. Please complete for single and combination injectable agents (excluding Byetta, Trulicity, Tzield, and Victoza) and Rybelsus.

1. Has the member tried metformin used in combination with Byetta, Trulicity, or Victoza?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XVII 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 XVII below.* ☐ No
3. If the answer to question 1 is no, has the member tried Byetta, Trulicity, or Victoza?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XVII below.*
   ☐ No. Please describe if there is a contraindication to Byetta, Trulicity, and Victoza.
   _____
4. If the request is for quantities exceeding the quantity limit, please complete Section XVI below.
5. 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.
   _____

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Section III. Please complete for alogliptin.

1. Has the member tried metformin used in combination with Januvia, saxagliptin, or Tradjenta?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XVII 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 XVII below.* ☐ No
3. If the answer to question 1 is no, has the member tried Januvia, saxagliptin, or Tradjenta?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XVII below.*
   ☐ No. Please describe if there is a contraindication to Januvia, saxagliptin, and Tradjenta.
4. If the request is for greater than one tablet per day, please complete Section XVI below.

Section IV. Please complete for Steglatro.

1. Has the member tried metformin used in combination with dapagliflozin, Invokana, or Jardiance?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XVII 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 XVII below.* ☐ No
3. If the answer to question 1 is no, has the member tried dapagliflozin, Invokana, or Jardiance?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XVII below.*
   ☐ No. Please describe if there is a contraindication to dapagliflozin, Invokana, and Jardiance.
4. If the request is for greater than one tablet per day, please complete Section XVI below.

Section V. Please complete for Tzield.

1. Is the prescriber an endocrinologist? ☐ Yes ☐ No
2. Please attach lab results documenting ≥ two islet autoantibodies.
3. Please complete the below lab test results as applicable.

   Fasting Plasma Glucose (FPG) Date obtained

   2-hour Plasma Glucose (2-h PG) Date obtained
4. Has the member been treated with Tzield previously? ☐ Yes ☐ No

Section VI. Please complete for Basaglar, Basaglar Tempo, insulin glargine-vfgn or Rezvoglar.

1. Has the member had an inadequate response or adverse reaction to insulin glargine (generic Lantus) prefilled syringe or vial?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XVII below.* ☐ No
2. For Basaglar and Basaglar Tempo, has the member had an inadequate response or adverse reaction to insulin glargine-vfgn prefilled syringe or vial or Rezvoglar?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XVII below.* ☐ No
3. For Basaglar Tempo, please provide medical necessity for use of the Tempo Pen formulation instead of the KwikPen formulation.

Section VII. Please complete for Admelog, Fiasp, Lyumjev, or Lyumjev Tempo.

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

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2. For Lyumjev Tempo, please provide medical necessity for use of the Tempo Pen formulation instead of the KwikPen formulation.

Section VIII. Please complete for Afrezza.

Please provide medical necessity for the use of an inhaled insulin product instead of an injectable or prefilled insulin syringe.

Section IX. Please complete for Humalog Tempo.

Please provide medical necessity for use of the Tempo Pen formulation instead of the KwikPen formulation.

Section X. Please complete 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 XVII below.* ☐ No

Section XI. Please complete for metformin extended-release, gastric tablet (generic Glumetza), and metformin extended-release, osmotic tablet.

1. Please attach medical records documenting an inadequate response (defined as ≥ 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 medical necessity for the use of the requested product instead of other metformin formulations available without prior authorization.

Section XII. Please complete 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 (defined as ≥ 90 days of therapy), allergic reaction, or adverse reaction to metformin tablets.
2. For Riomet ER, please attach medical records documenting an inadequate response (defined as ≥ 90 days of therapy) to metformin immediate-release solution formulation.

Section XIII. Please complete for metformin immediate-release 625 mg tablet.

Please provide medical necessity for the requested formulation instead of metformin tablets available without prior authorization.

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Section XIV. Please complete 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 XVII 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 XVII 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 XVII 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 XVI below.

Section XV. Please complete for Inpefa.

1. For an indication of reduction of risk of cardiovascular death, hospitalization for heart failure, and urgent heart failure visit, has the member tried or does the member have a contraindication to both dapagliflozin and Jardiance?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes in Section XVII below.* ☐ No
2. For an indication of reduction of risk of cardiovascular death, hospitalization for heart failure, and urgent heart failure visit in type 2 diabetes mellitus and chronic kidney disease with other cardiovascular risk factors, has the member tried two or does the member have a contraindication to all of the following: dapagliflozin, Invokana, Jardiance?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcome in Section XVII below.* ☐ No
3. If the request is for greater than one tablet per day, please complete Section XVI below.

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

Please describe the clinical rationale for exceeding the quantity limit.

Section XVII. 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.

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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.*

Section XVIII. Please complete and provide documentation for exceptions to Step Therapy.

1. Is the alternative drug required under the step therapy protocol contraindicated, or will likely cause an adverse reaction in, or physical or mental harm to the member? ☐ Yes ☐ No

   If yes, briefly describe details of contraindication, adverse reaction, or harm.

2. Is the alternative drug required under the step therapy protocol expected to be ineffective based on the known clinical characteristics of the member and the known characteristics of the alternative drug regimen?

   ☐ Yes ☐ No

   If yes, briefly describe details of known clinical characteristics of member and alternative drug regimen.

3. Has the member previously tried the alternative drug required under the step therapy protocol, or another alternative drug in the same pharmacologic class or with the same mechanism of action, and such alternative drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?

   ☐ Yes ☐ No

   If yes, please provide details for the previous trial.

   Drug name Dates/duration of use

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

   Briefly describe details of adverse reaction or inadequate response.

4. Is the member stable on the requested prescription drug prescribed by the health care provider, and switching drugs will likely cause an adverse reaction in or physical or mental harm to the member?

   ☐ Yes. Please provide details.

   ☐ No

Please continue to next page and complete Prescriber and Provider Information section.

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Prior Authorization Request Prescriber and Provider Information

Prescriber Information

Last name* First name* MI

NPI* Individual MH Provider ID

DEA No. Office Contact Name

Address City State Zip

Email address

Telephone No.* Fax No.*

** Required*

Please also complete for professionally administered medications, if applicable.

Start date End date

Servicing prescriber/facility name ☐ Same as prescribing provider

Servicing provider/facility address

Servicing provider NPI/tax ID No.

Name of billing provider

Billing provider NPI No.

Is this a request for recertification? ☐ Yes ☐ No

CPT code No. of visits J code No. of units

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 _____

Printed name of prescribing provider Date

(The form can either be signed by hand and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.)