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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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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.**

Medication information

Medication requested

- ☐ Aemcolo (rifamycin)
- ☐ amoxicillin/clavulanate extended-release
- ☐ Augmentin (amoxicillin/clavulanate 125/31.25 mg/5 mL suspension)
- ☐ azithromycin powder packet
- ☐ Baxdela (delafloxacin tablet)
- ☐ cefaclor extended-release
- ☐ cefaclor suspension
- ☐ 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, 60 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)
- ☐ Likmez (metronidazole oral suspension)
- ☐ linezolid suspension
- ☐ Lymepak (doxycycline 100 mg tablet pack)
- ☐ 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 25 mg/5 mL suspension
- ☐ nitrofurantoin 50 mg/5 mL suspension
- ☐ Nuzyra (omadacycline tablet)
- ☐ ofloxacin tablet
- ☐ pyrimethamine
- ☐ Sivextro (tedizolid tablet)
- ☐ Solosec (secnidazole)
- ☐ Xifaxan (rifaximin 550 mg)

Dose, frequency, and duration of medication requested

Indication or ICD-10 code, if applicable

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 formulation instead of 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 instead of alternative strengths available without PA.

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

Please describe prior trials and outcomes with doxycycline formulations that are available without PA in Section I above. Please describe medical necessity for the requested formulation instead of doxycycline formulations available without PA.

Section VI. Please also complete for requests for Lymepak.

Please describe prior trials and outcomes with all doxycycline formulations that are available without PA in Section I above. Please describe medical necessity for the requested formulation instead of doxycycline 100 mg formulations available without PA.

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

1. For minocycline immediate-release tablet, please describe prior trials and outcomes with minocycline capsules in Section I above. Please describe medical necessity for the dosage formulation instead of 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 XI. Please also complete for requests for cefaclor suspension, linezolid suspension, nitrofurantoin 25 mg/5 mL suspension, and nitrofurantoin 50 mg/5 mL suspension.

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

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

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

Section XIII. 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 XIV. 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.

Section XV. 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 XVI. Please also complete for requests for Lampit.

Member's current weight Date

Section XVII. Please also complete for requests for pyrimethamine.

Will the requested agent be used in combination with other agents for the diagnosis?

- ☐ Yes. Please provide drug name(s).
- ☐ No

Section XVIII. Please also complete for requests for Likmez.

Please describe prior trials and outcomes with metronidazole tablets in Section I above. Please describe medical necessity for the requested formulation instead of formulations available without PA.

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Section XIX. 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.)