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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Diabetes Medical Supplies
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**.

Product information

Device requested

- ☐ Cequr Simplicity
- ☐ Dexcom G6
  - ☐ Receiver
  - ☐ Sensor
  - ☐ Transmitter
- ☐ Dexcom G7
  - ☐ Receiver
  - ☐ Sensor
- ☐ Freestyle Libre 14 Day
  - ☐ Reader
  - ☐ Sensor
- ☐ Freestyle Libre 2
  - ☐ Reader
  - ☐ Sensor
- ☐ Freestyle Libre 3
  - ☐ Reader
  - ☐ Sensor
- ☐ Omnipod 5
  - ☐ Omnipod 5 Pod Pack
  - ☐ Omnipod 5 Intro Kit
- ☐ Omnipod Classic
  - ☐ Omnipod Classic Personal Diabetes Manager
  - ☐ Omnipod Classic Pod Pack
- ☐ Omnipod Dash
  - ☐ Omnipod Dash Intro Kit
  - ☐ Omnipod Dash Personal Diabetes Manager
  - ☐ Omnipod Dash Pod Pack
- ☐ V-Go

Non-drug product requested **Qty/30 days**

- ☐ Blood glucose testing strips > 100 units/30 days
  - ☐ 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 or include ICD-10 code, if applicable.)

☐ 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, Dexcom G7, Freestyle Libre 14 Day, Freestyle Libre 2, and Freestyle Libre 3 requests.

1. Is the member stabilized on the requested device? ☐ Yes. Please provide start date. ______ ☐ No

2. Is the member currently receiving treatment with insulin administration or an insulin pump? ☐ Yes ☐ No
3. 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 continuous blood glucose monitoring.

Section II. Please complete for Cequr Simplicity, Omnipod 5, Omnipod Classic, Omnipod Dash, Omnipod Go, and V-Go requests.

1. Is the member stabilized on the requested device? ☐ Yes. Please provide start date. ☐ No
2. Is the member currently testing blood glucose at least four times per day or using continuous glucose monitoring? ☐ Yes ☐ No
3. Is the member currently receiving treatment with insulin administration at least three times per day or 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 continuous subcutaneous inulin infusion.

Section III. Please complete for Cequr Simplicity, Dexcom G6, Dexcom G7, Freestyle Libre 14 Day, Freestyle Libre 2, Freestyle Libre 3, Omnipod 5, Omnipod Classic, Omnipod Dash, Omnipod Go, and V-Go recertification requests.

For Cequr Simplicity, Omnipod 5, Omnipod Classic, Omnipod Dash, Omnipod Go, 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.

Section IV. Please complete for Freestyle Neo requests.

Will the member be using a compatible continuous glucose monitoring device (i.e., Freestyle Libre 2, Freestyle Libre 3, Freestyle Libre 14 Day)?
- ☐ Yes

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☐ No. Please provide medical necessity for use of Freestyle Neo.

Section V. Please complete for all requests exceeding the quantity limit.

1. Is the member currently receiving treatment with insulin administration or an insulin pump? ☐ Yes. Please provide units/day. ☐ No
2. Does the member exhibit any of the following clinical characteristics? (Check all that apply.)
   - ☐ Yes
     - ☐ Injection site irritation. Were mitigation strategies attempted? ☐ Yes ☐ No
     - ☐ Adhesion failure. Were mitigation strategies attempted? ☐ Yes ☐ No
     - ☐ Lipoatrophy or lipohypertrophy at the injection site
     - ☐ Pooling of insulin at the injection site
   - ☐ No. Please provide medical necessity for the requested quantity.

Section VI. 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

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.)