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

over

Anti-Obesity 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

- ☐ benzphetamine
- ☐ diethylpropion
- ☐ diethylpropion ER
- ☐ Lomaira (phentermine 8 mg tablet) < 12 years or ≥ 18 years
- ☐ orlistat
- ☐ phendimetrazine
- ☐ phendimetrazine ER
- ☐ phentermine 15 mg, 30 mg capsule < 12 years
- ☐ phentermine 37.5 mg capsule, tablet < 12 years
- ☐ Saxenda (liraglutide)
- ☐ Wegovy (semaglutide injection)
- ☐ Zepbound (tirzepatide)
- ☐ Other

Dose and frequency of medication requested

Is the member stabilized on the requested medication? ☐ Yes. Please provide start date. ☐ No

Indication or ICD-10 code, if applicable

- ☐ Obesity*
- ☐ Overweight*
- ☐ Risk reduction of major adverse cardiovascular events with established cardiovascular disease and obesity or overweight
- ☐ Other

**Please note, Saxenda and Wegovy are not covered for the treatment of overweight or obesity for adults.*

Section I. Please complete for all requests.

1. Member's baseline weight ____ kg Date ____
2. Member's current weight ____ kg Date ____
3. Member's current height ____ cm Date ____
4. Member's baseline BMI ____ kg/m^2 Date ____
5. Member's current BMI ____ kg/m^2 Date ____
6. Has the member been counseled to continue reduced-calorie diet and increased physical activity?
   ☐ Yes ☐ No
7. Does the member have any of the following weight-related comorbid conditions?
   - Coronary heart disease or other atherosclerotic disease ☐ Yes ☐ No
   - Dyslipidemia ☐ Yes ☐ No
   - Hypertension ☐ Yes ☐ No
   - Non-alcoholic steatohepatitis (NASH) ☐ Yes ☐ No

Obstructive sleep apnea ☐ Yes ☐ No
Polycystic ovarian syndrome ☐ Yes ☐ No
Prediabetes ☐ Yes ☐ No
Systemic osteoarthritis ☐ Yes ☐ No
Type 2 diabetes mellitus ☐ Yes ☐ No
Other comorbidity ☐ Yes ☐ No

8. For Saxenda, Wegovy and Zepbound requests, will the requested agent be used in combination with another GLP-1 receptor agonist? ☐ Yes ☐ No
9. For members < 12 years of age for Lomaira and phentermine requests, please provide medical necessity to support the use of phentermine in a member < 12 years of age.
10. For benzphetamine, diethylpropion, diethylpropion ER, Lomaira, phendimetrazine, phendimetrazine ER, Saxenda for members <18 years of age, Wegovy for members <18 years of age, and Zepbound requests, has the member had a trial with phentermine with or without topiramate?
    ☐ Yes. Please list the dates/duration of trials and outcomes below. If the member had an adverse reaction, please attach medical records documenting adverse reaction.
    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, or other.
    ☐ No. Please attach medical records documenting a contraindication to phentermine.

Section II. Please also complete for indication of risk reduction of major adverse cardiovascular events for Wegovy requests.

1. Please indicate if the member has any of the following cardiovascular conditions. Check all that apply and please provide medical records documenting cardiovascular condition(s).
   ☐ History of myocardial infarction
   ☐ History of stroke (ischemic or hemorrhagic)
   ☐ Symptomatic peripheral arterial disease (e.g., intermittent claudication with ankle–brachial index <0.85, peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease)
2. Does the member have any of the following chronic medical conditions?
   Type 1 diabetes mellitus ☐ Yes ☐ No
   Type 2 diabetes mellitus ☐ Yes ☐ No
   New York Heart Association Class IV Heart Failure ☐ Yes ☐ No

Section III. Please complete for recertification requests.

1. Member's current weight Date
2. Does the member have improvement in measures of comorbid conditions? ☐ Yes ☐ No
   If yes, please describe.
3. Does the member have improvement in measures of comorbid conditions believed to be related to anti-obesity therapy despite lack of reduction in body weight? ☐ Yes ☐ No
   If yes, please describe.

over

4. For Wegovy recertification requests, does the member require use of Wegovy for cardiovascular protection and the benefit of cardiovascular protection outweighs the risk associated with use of GLP-1 agents?
   ☐ Yes, please explain and provide medical records documenting cardiovascular condition(s).
   ☐ No

Section IV. 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.

over

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

E-mail address

Telephone No.*

Fax No.* (Please provide fax number for PA response notification.)

** 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

Provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am either the prescribing provider or duly authorized to act on behalf of the provider identified in the Prescriber information section of this form. Any attached statement on 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.

Signature of provider or individual duly authorized to act on behalf of the provider:

Printed legal name and title of signatory above

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.)