



# 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.

<p><b>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</b></p> <p><input type="checkbox"/> <b>MassHealth Drug Utilization Review Program</b> Pharmacy: Fax: (877) 208-7428 - Tel: (800) 745-7318</p>
<p><b>MassHealth Managed Care Organization (MCO) and Accountable Care Partnership Plans (ACPP)</b></p> <p><input type="checkbox"/> <b>Fallon Health</b> Online Prior Authorization: <a href="http://go.covermymeds.com/OptumRx">go.covermymeds.com/OptumRx</a> Online Prior Authorization: <a href="http://providerportal.surescripts.net/ProviderPortal/optum">providerportal.surescripts.net/ProviderPortal/optum</a> Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033</p>
<p><input type="checkbox"/> <b>Health New England</b> Online Prior Authorization: <a href="http://go.covermymeds.com/OptumRx">go.covermymeds.com/OptumRx</a> Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545</p>
<p><input type="checkbox"/> <b>Mass General Brigham Health Plan</b> Online Prior Authorization (Non-Specialty Drugs): <a href="http://go.covermymeds.com/OptumRx">go.covermymeds.com/OptumRx</a> Online Prior Authorization (Specialty/Medical Drugs): <a href="http://provider.massgeneralbrighamhealthplan.org">provider.massgeneralbrighamhealthplan.org</a> Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555</p>
<p><input type="checkbox"/> <b>Tufts Health Plan</b> Online Prior Authorization: <a href="http://point32health.promptpa.com">point32health.promptpa.com</a> Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985</p>
<p><input type="checkbox"/> <b>WellSense Health Plan</b> Online Prior Authorization: <a href="http://wellsense.org/providers/ma/pharmacy/prior-authorizations">wellsense.org/providers/ma/pharmacy/prior-authorizations</a> Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822</p>

# Antidiabetic Agents

## Prior Authorization Request

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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](http://www.mass.gov/druglist).

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### Medication information

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

#### Single Injectable Agents

- 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
- liraglutide [Victoza] > 9 mL/30 days
- Mounjaro (tirzepatide)
- Ozempic (semaglutide injection)
- Trulicity (dulaglutide) > 2 mL/28 days
- Tzield (teplizumab-mzwv)

#### Single Oral Agents

- alogliptin
- Inpefa (sotagliflozin)
- Invokana (canagliflozin)
- metformin extended-release, gastric tablet [Glumetza]
- metformin extended-release, osmotic tablet
- metformin immediate-release 625 mg tablet
- metformin immediate-release solution  $\geq$  13 years of age
- miglitol
- Riomet ER (metformin extended-release suspension)
- Rybelsus (semaglutide tablet)
- saxagliptin
- Steglatro (ertugliflozin)
- Zituvio (sitagliptin)

#### Combination Injectable Agents

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

#### Insulin Agents

- Admelog (insulin lispro)
- Afrezza (insulin human inhalation powder)
- Apidra (insulin glulisine)
- 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)
- Invokamet (canagliflozin/metformin)
- Invokamet XR (canagliflozin/metformin extended release)
- pioglitazone/glimepiride
- Qtern (dapagliflozin/saxagliptin)
- repaglinide/metformin
- saxagliptin/metformin extended release
- 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

Type 2 diabetes mellitus and diabetic nephropathy with albuminuria

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. *Please inform the member, parent, or legal guardian to expect outreach from a MassHealth representative of care coordination services.*

**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 XVIII 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 XVIII 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 XVIII 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 liraglutide [generic Victoza]) and Rybelsus.**

1. Has the member tried metformin used in combination with Byetta, liraglutide (generic Victoza), or Trulicity?

Yes. Please list the drug names, dates/duration of use, and outcomes in Section XVIII 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 XVIII below.\*  No

3. If the answer to question 1 is no, has the member tried Byetta, liraglutide (generic Victoza), or Trulicity?

Yes. Please list the drug names, dates/duration of use, and outcomes in Section XVIII below.\*

No. Please describe if there is a contraindication to Byetta, liraglutide (generic Victoza), and Trulicity.

4. If the request is for quantities exceeding the quantity limit, please complete Section XVII below.
5. For Bydureon Bcise, Mounjaro, Ozempic, and Rybelsus, 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.

6. For Mounjaro, has the member tried Ozempic?

Yes. Please list the drug names, dates/duration of use, and outcomes in Section XVIII below.\*

No. Please describe if there is a contraindication to Ozempic.

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### Section III. Please complete for alogliptin and saxagliptin requests.

1. Has the member tried metformin used in combination with Januvia or Tradjenta?

Yes. Please list the drug names, dates/duration of use, and outcomes in Section XVIII 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 XVIII below.\*  No

3. If the answer to question 1 is no, has the member tried Januvia or Tradjenta?

Yes. Please list the drug names, dates/duration of use, and outcomes in Section XVIII below.\*

No. Please describe if there is a contraindication to Januvia and Tradjenta.

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

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### Section IV. Please complete for Zituvio requests.

1. Has the member tried metformin used in combination with alogliptin, saxagliptin, or Tradjenta?

Yes. Please list the drug names, dates/duration of use, and outcomes in Section XVIII 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 XVIII below.\*  No

3. If the answer to question 1 is no, has the member tried alogliptin, saxagliptin, or Tradjenta?

Yes. Please list the drug names, dates/duration of use, and outcomes in Section XVIII below.\*

No. Please describe if there is a contraindication to alogliptin, saxagliptin, and Tradjenta.

4. Please provide clinical rationale for the requested agent instead of Januvia.

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

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### Section V. Please complete for Invokana and Steglatro requests.

For Invokana for type 2 diabetes mellitus and diabetic nephropathy with albuminuria requests, only question 4 is required.

1. Has the member tried metformin used in combination with dapagliflozin or Jardiance?

Yes. Please list the drug names, dates/duration of use, and outcomes in Section XVIII 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 XVIII below.\*  No

3. If the answer to question 1 is no, has the member tried dapagliflozin or Jardiance?

Yes. Please list the drug names, dates/duration of use, and outcomes in Section XVIII below.\*

No. Please describe if there is a contraindication to dapagliflozin and Jardiance.

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

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**Section VI. Please complete for Tzield requests.**

1. Is the prescriber an endocrinologist?  Yes  No. Please attach consultation notes from an endocrinologist addressing the use of the requested agent.
2. Please attach lab results documenting  $\geq$  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

A1C: please document lab values from previous 12 months below.

Lab value  Date obtained

Lab value  Date obtained

4. Has the member been treated with Tzield previously?  Yes  No
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**Section VII. Please complete for Basaglar, Basaglar Tempo, insulin glargine-vfqn, and Rezvoglar requests.**

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

  

**Section VIII. Please complete for Admelog, Apidra, Fiasp, Lyumjev, and Lyumjev Tempo requests.**

1. Has the member had an inadequate response or adverse reaction to insulin lispro (generic Humalog) or insulin aspart (generic Novolog)?  
 Yes. Please list the drug names, dates/duration of use, and outcomes in Section XVIII below.\*  No
2. For Lyumjev Tempo, please provide medical necessity for use of the Tempo Pen formulation instead of the KwikPen formulation.

  

**Section IX. Please complete for Afrezza requests.**

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

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**Section X. Please complete for Humalog Tempo requests.**

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

  

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**Section XI. Please complete for Humulin N requests.**

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 XVIII below.\*  No

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

1. Please attach medical records documenting an inadequate response (defined as  $\geq 90$  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.

  

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

1. Is there a medical necessity for the liquid formulation?

Yes. Please explain.

No. Please attach medical records documenting an inadequate response (defined as  $\geq 90$  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  $\geq 90$  days of therapy) to metformin immediate-release solution formulation.

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**Section XIV. Please complete for metformin immediate-release 625 mg tablet requests.**

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

  

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**Section XV. Please complete for miglitol requests.**

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 XVIII 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 XVIII 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 XVIII 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 XVII below.

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**Section XVI. Please complete for Inpefa requests.**

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 XVIII 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 XVIII below.\*  No
3. If the request is for greater than one tablet per day, please complete Section XVII below.

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**Section XVII. Please complete for requests for quantities above quantity limits.**

1. Please describe the clinical rationale for exceeding the quantity limit or why dose cannot be consolidated.
2. For Byetta, Trulicity, and Victoza, will the requested agent be used in combination with another GLP-1 receptor agonist?  Yes  No

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**Section XVIII. 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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**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

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



# Prior Authorization Request Prescriber and Provider Information

## Prescriber information

Last name*	<input type="text"/>	First name*	<input type="text"/>	MI	<input type="text"/>
NPI*	<input type="text"/>	Individual MH Provider ID	<input type="text"/>		
DEA No.	<input type="text"/>	Office Contact Name	<input type="text"/>		
Address	<input type="text"/>	City	<input type="text"/>	State	<input type="text"/>
		Zip	<input type="text"/>		
E-mail address	<input type="text"/>				
Telephone No.*	<input type="text"/>				
Fax No.* (Please provide fax number for PA response notification.)	<input type="text"/>				

\* Required

## Please also complete for professionally administered medications, if applicable.

Start date	<input type="text"/>	End date	<input type="text"/>		
Servicing prescriber/facility name	<input type="text"/>	<input type="checkbox"/>	Same as prescribing provider		
Servicing provider/facility address	<input type="text"/>				
Servicing provider NPI/tax ID No.	<input type="text"/>				
Name of billing provider	<input type="text"/>				
Billing provider NPI No.	<input type="text"/>				
Is this a request for recertification?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
CPT code	<input type="text"/>	No. of visits	<input type="text"/>	J code	<input type="text"/>
				No. of units	<input type="text"/>

## 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

<input type="text"/>	Date	<input type="text"/>
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(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.)