

Health Safety Net Prior Authorization Request Administrative Information

Patient 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

Health Safety Net 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 fax or submit this completed and signed form according to the Plan's contact information below.

Health Safety Net Plan
MassHealth Drug Utilization Review Program Pharmacy: Fax: (877) 208-7428 - Tel: (800) 745-7318

Please refer to the following table for guidance on filling out this PA form.

Complete Section I for all brand medications not on the Brand Name Preferred Over Generic Drug List.
 Complete all pertinent sections as described below.

Brand Medication Request	Section I
Non-Preferred Generic Request	Section II
Glucagon-like-peptide-1 (GLP-1) Agonist Request	Section III
Androgen Request	Section IV
Cerebral Stimulant Request	Section V
Preferred Non-Drug Product Request	Section VI
Opioid Dependence Request	Section VII
Opioid Request	Section VIII
Phosphodiesterase (PDE) Inhibitor Request	Section IX
Pharmaceutical Compound Request	Section X
Previous Trials	Section XI
Recertification Request	Section XII

Health Safety Net Prior Authorization Request

The MassHealth Drug Utilization Review (DUR) Program reviews Health Safety Net (HSN) requests for prior authorization (PA) on the basis of medical necessity. If HSN approves the request, payment is still subject to all general conditions of HSN, including current patient eligibility, other insurance, and program restrictions. HSN will notify the requesting provider and patient 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 reimbursable products, can be found within the MassHealth Drug List at www.mass.gov/druglist.

Medication information

Medication requested

Brand name

Generic of current Brand Name Preferred Over Generic Drug List agent

Dose and frequency of medication requested

Indication or ICD-10 code, if applicable

Section I. Please complete for all requests for brand medications not on the Brand Name Preferred Over Generic Drug List. Prescribers should first submit for coverage through manufacturers' Patient Assistance Programs (PAP) whenever available.

Please note: any individual drug criteria must be met first, if applicable.

1. Does the manufacturer offer a PAP for the requested agent? Yes No
2. If the answer to question 1 is yes, has the prescriber submitted for coverage through manufacturer's PAP?
 Yes. Please provide the following information.

Date of submission

Outcome Denied Pending

If the request for coverage was denied, please attach a copy of the denial notification.

No. Please provide information regarding why the patient is ineligible for the PAP.

3. Has the patient tried all other clinically appropriate reimbursable alternatives available without PA (i.e., generic medications and agents on the Brand Name Preferred Over Generic Drug List)?
 Yes. Please list the drug names, dates/duration of use, and outcomes in Section XI below.*
 No. Please describe the medical necessity for the requested brand name agent instead of all reimbursable alternatives available without PA.

Section II. Please complete for requests for non-preferred generics.

Please note: any individual drug criteria must be met first, if applicable.

Has the patient tried a brand-name product therapeutically equivalent to the non-preferred generic product requested?

Yes. Please list the drug name, dates/duration of use, and outcome in Section XI below.* In addition, provide supporting documentation (e.g., copies of medical records and/or office notes).

No. Please explain why not. Attach a letter with additional information regarding trials, as applicable.

Section III. Please complete for GLP-1 agonist requests.

Please note: Health Safety Net does not pay for any drug when used for the treatment of obesity as described in 101 CMR 613.03(2)(e): Noncovered Services. For additional information, go to www.mass.gov/regulations/101-CMR-61300-health-safety-net-eligible-services.

1. Has the member tried metformin used in combination with liraglutide (generic Victoza)?
 Yes. Please list the drug names, dates/duration of use, and outcomes in Section XI 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 outcomes in Section XI below.* No
3. If the answer to question 1 is no, has the member tried liraglutide (generic Victoza)?
 Yes. Please list the drug name, dates/duration of use, and outcomes in Section XI below.*
 No. Please describe if there is a contraindication to liraglutide (generic Victoza).

4. Has the member tried a sodium-glucose cotransporter 2 (SGLT-2) inhibitor?
 Yes. Please list the drug names, dates/duration of use, and outcomes in Section XI below.*
 No. Please describe if there is a contraindication to SGLT-2 inhibitors.

5. Has the member tried pioglitazone?
 Yes. Please list the drug names, dates/duration of use, and outcomes in Section XI below.*
 No. Please describe if there is a contraindication to pioglitazone.

6. For Mounjaro, Trulicity, or Rybelsus requests, has the patient had a trial with Ozempic?
 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 describe if there is a contraindication to Ozempic.

7. Will the requested agent be used in combination with another GLP-1 or glucose-dependent insulinotropic polypeptide (GIP)/GLP-1 agonist?
 Yes. Please complete information for medications requested and select the reason for polypharmacy.

Drug name Dates/duration of use

Drug name Dates/duration of use

Member is transitioning from one GLP-1 or GIP/GLP-1 agonist to another and prior GLP-1 or GIP/GLP-1 agonist use will be discontinued.

Other. Please explain.

No

8. If the request is for quantities exceeding the quantity limit, please describe the clinical rationale for exceeding the quantity limit or why dose cannot be consolidated.

Section IV. Please complete for all androgen requests.

Please note: Health Safety Net does not pay for any drug when used for the treatment of sexual dysfunction as described in 130 CMR 406.413(B): Drug Exclusions. For additional information, go to www.mass.gov/regulations/130-CMR-406000-pharmacy-services.

1. Is the patient stabilized on the requested medication? Yes. Please provide start date. No
2. Please provide any lab test results that confirm the diagnosis as indicated above.

Test Lab value

Reference range Date obtained

Test Lab value

Reference range Date obtained

Test Lab value

Reference range Date obtained

3. Please provide any other pertinent information.

Section V. Please complete for all cerebral stimulant requests above quantity limits.

1. Quantity requested per month Total quantity of all stimulants combined
2. Please provide medical necessity for an increased dosage that results in requiring quantities that exceed the determined limits.

3. Please describe your new treatment plan for managing this patient's condition, including discontinuation of any medications because of the addition of medication requested.

Section VI. Please complete for all non-drug pharmacy product requests.

For continuous glucose monitoring (CGM) products, please complete questions 1 through 5, as applicable. For continuous subcutaneous insulin infusion (CSII) products, please complete questions 1-3 and 6-7, as applicable. For preferred diabetic testing supplies exceeding quantity limits, please complete questions 2 and 8.

1. Is the patient stabilized on the requested device? Yes. Please provide start date. No
2. Please indicate the quantity requested as applicable.

Pod unit(s) per days Test strips strips per 30 days

Receiver unit(s) per 365 days Transmitter unit(s) per 90 days

Sensor unit(s) per days Other

3. For CGM and CSII requests exceeding the quantity limits, does the patient 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.

4. Is the patient currently receiving treatment with insulin administration or an insulin pump?

Yes. Please provide units/day.

No. Please explain.

5. Has the patient experienced any of the following? (Check all that apply.)

Yes

Two hypoglycemic events with blood glucose of < 54 mg/dL (3.0 mmol/L) within the last 12 months

One hypoglycemic event with blood glucose of < 54 mg/dL (3.0 mmol/L) that required third-party assistance for treatment within the past 12 months

No. Please explain why the patient is a candidate for continuous blood glucose monitoring.

6. Is the patient currently testing blood glucose at least four times per day or using CGM? Yes No

7. Is the patient currently receiving treatment with insulin administration at least three times per day or an

insulin pump? Yes. Please provide units/day.

No. Please explain.

8. For preferred diabetic testing supplies exceeding the quantity limits, please provide medical necessity for increased testing and treatment plan describing self-testing frequency.

Section VII. Please complete for all opioid dependence requests.

For concurrent therapy with opioid agents, please see Section VIII below. For buprenorphine/naloxone film and tablet doses exceeding 32 mg/day, please complete question 1. For buprenorphine sublingual tablet, please complete questions 1 through 6, as applicable.

1. For buprenorphine sublingual tablet, and buprenorphine/naloxone film and tablet, doses exceeding 32 mg/day, please document medical necessity for high dose below.

2. Is the patient pregnant? Yes. Anticipated date of delivery No

3. Is the patient breastfeeding? Yes No

4. Does the patient have moderate to severe hepatic impairment? Yes No

5. Does the patient have a documented allergy to naloxone? Yes No

If yes, please provide medical records documenting the allergic reaction.

6. If you answered No to the four questions above, please provide clinical rationale for prescribing buprenorphine instead of buprenorphine/naloxone.

Section VIII. Please complete for all opioid requests as applicable.

1. For codeine and tramadol products for patients < 12 years of age, please provide clinical rationale for use.

2. For Journavx above quantity limits (>29 units/60 days), please complete the following.

Is the diagnosis for a new acute episode of moderate to severe pain? Yes No

Please provide medical necessity for another 14-day course of therapy with the requested agent.

3. Please complete for requests above established dose limits. For all opioids, please provide medical records documenting treatment plan, including clinical rationale for high dose and titration of medication up to current dose. In addition, please provide a signed and dated patient-prescriber agreement and a consult from a pain specialist recommending the requested dose for this patient. If a current pain consult is not available, please provide the anticipated date of upcoming pain consult. If there are plans to initiate a taper of the requested medication within the next 90 days, please provide medical records documenting treatment plan.

Has the patient been offered and/or given a prescription for naloxone treatment?

Yes No. If No, please provide details.

4. Please complete for requests for high-dose, short-acting opioids as monotherapy. Please provide medical records documenting treatment plan, including clinical rationale for use of high-dose, short-acting opioids without a long-acting opioid agent. In addition, please provide clinical rationale for high dose and titration of medication up to current dose, a signed and dated patient-prescriber agreement, and a consult from a pain specialist recommending the requested dose for this patient.

Has the patient been offered and/or given a prescription for naloxone treatment?

Yes No. If No, please provide details.

5. Please complete for requests above established quantity limits (except Journavx; for Journavx, see question 2 above). Can the requested dose be obtained by using products within established quantity limits (i.e., for oxycodone ER 20 mg, two tablets twice daily could be consolidated to one oxycodone ER 40 mg tablet twice daily)? Yes No. If dose consolidation is not an option, please explain why.

6. Please complete for requests for duplicate short-acting or long-acting opioids. Please provide clinical rationale for duplicate therapy including plan to consolidate therapy.

7. For concurrent therapy with opioid dependence agents, please complete the following.

Are you the prescriber of both buprenorphine/naloxone or buprenorphine and the opioid? Yes No

Prior to continuing buprenorphine/naloxone or buprenorphine therapy, will the patient be discontinuing the opioid(s)? Yes No

Please document the medical necessity for concurrent buprenorphine/naloxone or buprenorphine and opioid therapy. Please submit medical records supporting the medical necessity, including the specific pain that the current opioid is being used to treat.

Please document the complete treatment plan, including expected duration of therapy for this patient in regard to acute pain management with concurrent buprenorphine/naloxone or buprenorphine and opioid therapy.

Section IX. Please complete for phosphodiesterase (PDE) inhibitor requests.

Please note: Health Safety Net does not pay for any drug when used for the treatment of sexual dysfunction as described in 130 CMR 406.413(B): Drug Exclusions. For additional information, go to www.mass.gov/regulations/130-CMR-406000-pharmacy-services.

For sildenafil tablet [Revatio], please complete questions 1 and 2. For sildenafil oral suspension [Revatio], please complete questions 1, 2, and 5. For tadalafil tablet, please complete questions 1-4.

1. Please indicate prescriber specialty. Cardiology Pulmonology Other
2. Will the requested agent be administered concurrently with Adempas? Yes. Please explain below. No
3. Has the patient tried sildenafil 20 mg tablet [Revatio]?
 Yes. Please list the dates/duration of use and outcomes in Section XI below.*
 No. Does the patient have a contraindication to sildenafil? Please explain.
4. Is the patient treatment-naïve? Yes No
If Yes, will the requested agent be used in combination with ambrisentan? Yes No
5. For sildenafil oral suspension [Revatio], please provide medical necessity for the use of the requested formulation instead of sildenafil tablet.

Section X. Please complete for pharmaceutical compound requests.

1. Has patient tried other medications to treat this condition?
 Yes. Please list the drug names, dates/duration of use, and outcomes in Section XI below.* You may be asked to provide supporting documentation (e.g., copies of medical records, office notes).
 No. Explain why not (attach a letter describing medical necessity, as applicable).
2. Please explain medical necessity of requested pharmaceutical compound and provide medical necessity for the included inactive ingredients.

Section XI. Please complete for all requests as applicable.

Please provide the following information regarding previous trials.*

Drug name Dates/duration of use

Dose and frequency

Did patient experience any of the following? Adverse reaction Inadequate response Other

Briefly describe details of adverse reaction, inadequate response, or other.

Drug name Dates/duration of use

Dose and frequency

Did patient experience any of the following? Adverse reaction Inadequate response Other

Briefly describe details of adverse reaction, inadequate response, or other.

Drug name Dates/duration of use

Dose and frequency

Did patient experience any of the following? Adverse reaction Inadequate response Other

Briefly describe details of adverse reaction, inadequate response, or other.

Drug name Dates/duration of use

Dose and frequency

Did patient experience any of the following? Adverse reaction Inadequate response Other

Briefly describe details of adverse reaction, inadequate response, or other.

**Attach a letter with additional information regarding medication trials, as applicable.*

Section XII. Please also complete for recertification requests.

1. Please provide the patient's therapeutic response to treatment.

2. For brand medications not on the Brand Name Preferred Over Generic Drug List, has the patient tried all other clinically appropriate reimbursable alternatives available without PA (i.e., generic medications and agents on the Brand Name Preferred Over Generic Drug List)?

Yes. Please list the drug names, dates/duration of use, and outcomes in Section XI above.

No. Please describe the medical necessity for the requested brand name agent instead of all reimbursable alternatives available without PA.

3. For CGM requests, has the patient's continuous blood glucose monitoring data been reviewed and used to monitor or adjust the antidiabetic treatment plan?

Yes No. Please describe why not.

4. For CSII intro kits/personal diabetes managers, please provide clinical rationale why replacement is not covered by manufacturer warranty.

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

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.)