



Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
 P.O. Box 2586, Worcester, MA 01613-2586  
**Fax:** 1-877-208-7428      **Phone:** 1-800-745-7318

## Injectable Antibiotic 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](http://www.mass.gov/druglist).

### Member information

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_  
 MassHealth member ID # \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Gender (Check one.)  F  M      Member's place of residence  home  nursing facility

### Medication information

#### Medication requested

- |   |   |
|---|---|
| <input type="checkbox"/> Avycaz (ceftazidime/avibactam)   | <input type="checkbox"/> Synercid (quinupristin/dalfopristin) |
| <input type="checkbox"/> Baxdela (delafloxacin injection) | <input type="checkbox"/> Teflaro (ceftaroline)                |
| <input type="checkbox"/> Dalvance (dalbavancin)           | <input type="checkbox"/> tigecycline                          |
| <input type="checkbox"/> daptomycin                       | <input type="checkbox"/> Vabomere (meropenem/vaborbactam)     |
| <input type="checkbox"/> linezolid injection              | <input type="checkbox"/> Vibativ (telavancin)                 |
| <input type="checkbox"/> Orbactiv (oritavancin)           | <input type="checkbox"/> Zerbaxa (ceftolozane/tazobactam)     |
| <input type="checkbox"/> Sivextro (tedizolid injection)   |   |

**Drug Code (if applicable)** \_\_\_\_\_

**Dose, frequency and duration of medication requested** \_\_\_\_\_

Dose \_\_\_\_\_ Frequency \_\_\_\_\_ Duration \_\_\_\_\_

- Naïve to therapy  Continuation of therapy

#### Indication (Check all that apply.)

- |   |   |
|---|---|
| <input type="checkbox"/> Bacteremia                                       | <input type="checkbox"/> Complicated urinary tract infection (cUTI)   |
| <input type="checkbox"/> Bone or joint infection:<br>_____                | <input type="checkbox"/> Endocarditis   |
| <input type="checkbox"/> Central nervous system (CNS) infection:<br>_____ | <input type="checkbox"/> Hospital-acquired (nosocomial) pneumonia   |
| <input type="checkbox"/> Community-acquired pneumonia (CAP)               | <input type="checkbox"/> Skin and soft tissue infection (SSTI):<br><input type="checkbox"/> Acute <input type="checkbox"/> Complicated <input type="checkbox"/> Uncomplicated |
| <input type="checkbox"/> Complicated intra-abdominal infection (cIAI)     | <input type="checkbox"/> Ventilator-associated bacterial pneumonia  |
|   | <input type="checkbox"/> Other infection: _____   |

#### Please indicate the infecting organism.

- |  |  |
|--|--|
| <input type="checkbox"/> Methicillin-resistant Staphylococcus aureus (MRSA)<br><input type="checkbox"/> Confirmed <input type="checkbox"/> Suspected | <input type="checkbox"/> Vancomycin-resistant Enterococcus (VRE) |
| <input type="checkbox"/> Non-MRSA/non-VRE: _____<br><input type="checkbox"/> Confirmed <input type="checkbox"/> Suspected                            |  |

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**Section I. Please complete for all requests.**

1. 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.  
\_\_\_\_\_
2. Please list previous antibiotic trials for the requested indication including outcomes.\*  
Drug \_\_\_\_\_ Outcome \_\_\_\_\_ Dates of use \_\_\_\_\_  
Drug \_\_\_\_\_ Outcome \_\_\_\_\_ Dates of use \_\_\_\_\_
3. For requests for Avycaz and Zerbaxa for a diagnosis of complicated intra-abdominal infection (cIAI), will the member be using the requested medication concurrently with metronidazole?  
 Yes  
 No. Please explain. \_\_\_\_\_

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

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**Section II. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.**

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**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.\* \_\_\_\_\_

\* Required

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**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 (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

**Signature required** \_\_\_\_\_

Printed name of prescribing provider \_\_\_\_\_ Date \_\_\_\_\_