



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

## Antidiabetic 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](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 (Check one or all that apply.)**

#### Single Injectable Agents

- Adlyxin (lixisenatide)
- Bydureon (exenatide extended-release auto-injection)
- Ozempic (semaglutide)
- Symlin (pramlintide)
- Tanzeum (albiglutide)
- Trulicity (dulaglutide)
- Victoza (liraglutide)

#### Single Oral Agents

- alogliptin
- Avandia (rosiglitazone)
- Cycloset (bromocriptine 0.8 mg tablet)
- Fortamet (metformin extended-release)
- Glumetza (metformin extended-release)
- metformin solution ≥ 13 years of age
- Steglatro (ertugliflozin)

#### Combination Injectable Agents

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

#### Insulin Agents

- Admelog (insulin lispro)
- Afrezza (insulin human inhalation powder)
- Basaglar (insulin glargine)
- Fiasp (insulin aspart vial)

#### Combination Oral Agents

- Actoplus Met XR (pioglitazone/metformin extended-release)
- alogliptin/metformin
- alogliptin/pioglitazone
- Glyxambi (empagliflozin/linagliptin)
- Invokamet XR (canagliflozin/metformin extended-release)
- Jentaduo XR (linagliptin/metformin extended-release)
- pioglitazone/glimepiride
- pioglitazone/metformin
- Qtern (dapagliflozin/saxagliptin)
- repaglinide/metformin
- Segluromet (ertugliflozin/metformin)
- Steglujan (ertugliflozin/sitagliptin)
- Synjardy (empagliflozin/metformin)
- Synjardy XR (empagliflozin/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** \_\_\_\_\_

Is the member stabilized on the requested medication?  Yes. Dates of use \_\_\_\_\_  No

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

Type 1 Diabetes Mellitus  Type 2 Diabetes Mellitus  Other \_\_\_\_\_

What is the member's most recent hemoglobin A1C? \_\_\_\_\_ Date \_\_\_\_\_

Please list all other antidiabetic medications currently prescribed for the member for this indication.

Drug \_\_\_\_\_ Dose and Frequency \_\_\_\_\_ Dates of use \_\_\_\_\_

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**Section I. Please complete for all requests for single and combination injectable and oral agents, except metformin extended-release (generic Fortamet and Glumetza), metformin solution, and Symlin.**

For pioglitazone/metformin, metformin trial only is required. For ActoplusMet XR, in addition to metformin trial, attach medical records of failed trial with pioglitazone/metformin.

1. Has the member tried metformin and a dipeptidyl peptidase (DPP)-IV inhibitor, exenatide, insulin therapy, pioglitazone, a sodium glucose cotransporter (SGLT)-2 inhibitor, or a sulfonylurea?

Yes. Please list the drug names, dates/duration of use and outcomes below.

Drug \_\_\_\_\_ Dates/duration \_\_\_\_\_  Adverse reaction  Inadequate response  Other  
Briefly describe details of adverse reaction, inadequate response, or other.

Drug \_\_\_\_\_ Dates/duration \_\_\_\_\_  Adverse reaction  Inadequate response  Other  
Briefly describe details of adverse reaction, inadequate response, or other.

No. Please document if there is a contraindication to DPP-IV inhibitors, exenatide, insulin therapy, metformin, pioglitazone, SGLT-2 inhibitors, and sulfonylureas. \_\_\_\_\_

2. Please list any other prior antidiabetic trials. Please list the drug names, dates/duration of use and outcomes below.

Drug \_\_\_\_\_ Dates/duration \_\_\_\_\_  Adverse reaction  Inadequate response  Other  
Briefly describe details of adverse reaction, inadequate response, or other.

Drug \_\_\_\_\_ Dates/duration \_\_\_\_\_  Adverse reaction  Inadequate response  Other  
Briefly describe details of adverse reaction, inadequate response, or other.

**Section II. Please complete for requests for Basaglar.**

Has the member had an inadequate response or adverse reaction to Lantus Solostar prefilled syringe?

Yes. Please list the dates/duration of use and outcomes below.

Dates/duration \_\_\_\_\_  Adverse reaction  Inadequate response  Other  
Briefly describe details of adverse reaction, inadequate response, or other.

No

**Section III. Please complete for requests for Admelog or Fiasp.**

Has the member had an inadequate response or adverse reaction to Apidra, Humalog, or Novolog?

Yes. Please list the drug names, dates/duration of use and outcomes below.

Drug \_\_\_\_\_ Dates/duration \_\_\_\_\_  Adverse reaction  Inadequate response  Other

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

No

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

Does the member have a medical necessity for the use of an inhaled insulin product over an injectable or prefilled insulin syringe?

Yes. Please describe. \_\_\_\_\_

No

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

Please describe the clinical rationale for exceeding the quantity limit. \_\_\_\_\_

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**Section VI. Please complete for requests for metformin extended-release (generic Fortamet and Glumetza).**

1. Please attach medical records documenting an inadequate response or adverse reaction despite 90 days of therapy with a generic extended-release metformin formulation at the requested dose that is AB-rated to Glucophage XR.
2. For metformin extended-release (generic Glumetza), please provide clinical rationale for the use of this product over other available metformin formulations.

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**Section VII. Please complete for requests for metformin solution.**

Is there a medical necessity for the liquid formulation?

Yes. Please explain. \_\_\_\_\_

No. Please attach medical records documenting an inadequate response or adverse reaction to generic metformin tablets.

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**Section VIII. Please complete for requests for Symlin.**

1. Has the member had an inadequate response to mealtime insulin therapy?

Yes. Please list the drug names, dates/duration of use and outcomes below.

Drug \_\_\_\_\_ Dates/duration \_\_\_\_\_

Briefly describe details of inadequate response.

No

2. Is the member on any medications that stimulate gastrointestinal motility or for the treatment of gastroparesis?

Yes. Please explain. \_\_\_\_\_

No

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**Section IX. 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 \_\_\_\_\_