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

Print Clear

Oral Antibiotics and Anti-Infectives 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.**

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

- ☐ amoxicillin/clavulanate extended-release
- ☐ Augmentin (amoxicillin/clavulanate 125/31.25 mg/5 mL suspension)
- ☐ Baxdela (delafloxacin tablet)
- ☐ Cedax (ceftibuten)
- ☐ cefaclor extended-release
- ☐ cefadroxil tablet
- ☐ cefixime
- ☐ cephalexin 333 mg capsule
- ☐ cephalexin 750 mg capsule
- ☐ ciprofloxacin extended-release
- ☐ clarithromycin extended-release
- ☐ Coartem (artemether/lumefantrine) > 24 units/365 days
- ☐ Daraprim (pyrimethamine)
- ☐ Dificid (fidaxomicin)
- ☐ Doryx (doxycycline hyclate delayed-release 120 mg tablet)
- ☐ doxycycline hyclate 75 mg, 150 mg tablet
- ☐ doxycycline hyclate delayed-release 50 mg, 75 mg, 100 mg, 150 mg, 200 mg tablet
- ☐ doxycycline monohydrate 40 mg capsule
- ☐ doxycycline monohydrate 75 mg capsule
- ☐ doxycycline monohydrate 150 mg capsule
- ☐ doxycycline monohydrate 150 mg tablet
- ☐ Ketek (telithromycin)
- ☐ linezolid suspension, tablet
- ☐ mebendazole
- ☐ metronidazole 375 mg capsule
- ☐ minocycline extended-release 45 mg, 90 mg, 135 mg tablet
- ☐ minocycline tablet
- ☐ moxifloxacin tablet
- ☐ Nuzyra (omadacycline tablet)
- ☐ ofloxacin tablet
- ☐ quinine
- ☐ Sivextro (tedizolid tablet)
- ☐ Solosec (secnidazole)
- ☐ tinidazole
- ☐ Xifaxan (rifaximin)
- ☐ Ximino (minocycline extended-release capsule)
- ☐ Zmax (azithromycin extended-release)

Dose, frequency and duration _____

Indication _____

Section I. Please complete for requests for amoxicillin/clavulanate extended-release, cefaclor extended-release, ciprofloxacin extended-release, and clarithromycin extended-release.

Please describe the medical necessity for the use of an extended-release dosage form over immediate-release formulations of the requested agent. Please describe prior trials and outcomes with the immediate-release formulation and additional antibiotics, if applicable.

_____

Section II. Please complete for requests for cefadroxil tablet, cephalexin 333 mg and 750 mg capsule, metronidazole 375 mg, and Zmax.

Please describe the outcomes of prior trials with formulations of the requested antibiotic that are available without PA. Include medical necessity for the use of the requested antibiotic over alternative strengths that do not require a prior authorization.

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Section III. Please complete for all requests for doxycycline agents requiring prior authorization.

Please describe the outcomes of prior trials with doxycycline formulations that are available without PA including dates of trials, and provide clinical rationale for the requested formulation.

_____

Section IV. For requests for Ketek, please attach supporting documentation to establish medical necessity.

Section V. Please complete for requests for Cedax and cefixime.

Is the member completing a course of therapy that was initiated in the hospital? ☐ Yes ☐ No

If the answer to the above question is no, please note if the member experienced any of the following with cefdinir and/or cefpodoxime.

☐ cefdinir ☐ Adverse reaction ☐ Inadequate response ☐ Other _____

☐ cefpodoxime ☐ Adverse reaction ☐ Inadequate response ☐ Other _____

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

_____

Section VI. Please complete for requests for Xifaxan.

1. For the diagnosis of hepatic encephalopathy, did the member experience any of the following with lactulose?
   ☐ Adverse reaction ☐ Inadequate response ☐ Other _____
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
2. For the diagnosis of irritable bowel syndrome with diarrhea, has the member had a trial with three of the following: loperamide, diphenoxylate/atropine, bile acid sequestrant, bismuth subsalicylate, bulk-forming agent, tricyclic antidepressant (TCA)?
   ☐ Yes. Please provide details for the previous trials below.
   Drug _____ Dates of use _____ Outcome _____
   Drug _____ Dates of use _____ Outcome _____
   Drug _____ Dates of use _____ Outcome _____
   ☐ No. Please explain why these agents have not been tried.
   _____

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Section VII. Please complete for requests for linezolid tablet and Sivextro tablet.

1. Does the member have a diagnosis of vancomycin-resistant enterococcus? ☐ Yes ☐ No
   For Sivextro, if the answer to the above question is yes, please note if the member experienced any of the following with linezolid.
   ☐ Adverse reaction ☐ Inadequate response ☐ Other _____
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
2. Does the member have a diagnosis of suspected or confirmed methicillin resistant staphylococcus aureus (MRSA)? ☐ Yes ☐ No
3. Is there a culture for MRSA that is positive?
   ☐ 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.
   _____
4. Please list previous antibiotic trials and/or sensitivities including outcomes and dates.*
   ☐ sulfamethoxazole/ trimethoprim ☐ clindamycin ☐ doxycycline or minocycline ☐ vancomycin IV
   ☐ Other _____
   Outcome/Sensitivities _____ Dates of use _____
   Outcome/Sensitivities _____ Dates of use _____

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

Section VIII. Please complete for requests for mebendazole, moxifloxacin tablet, ofloxacin tablet, Solosec, and tinidazole.

Please describe the outcomes of prior trials with available alternatives, including dates of trials.

_____

Section IX. For requests for minocycline extended-release 45 mg, 90 mg, 135 mg tablets, minocycline tablets, and Ximino, please attach supporting documentation of a trial with minocycline capsules and clinical rationale for the dosage form over immediate-release capsules.

Section X. Please complete for requests for Dificid.

Has the member had a trial with oral vancomycin?

☐ Yes. Please provide details for the trial below.
Dates of use _____ Outcome _____

☐ No. Please explain why oral vancomycin has not been tried.

_____

Section XI. Please also complete for Augmentin 125/31.25 mg/5 mL suspension requests.

Please provide clinical rationale for not using 250/62.5 mg/5 mL formulation.

_____

Section XII. Please complete for requests for Baxdela tablet and Nuzyra tablet.

1. Does the member have a diagnosis of suspected or confirmed methicillin resistant staphylococcus aureus (MRSA)? ☐ Yes ☐ No
2. 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.

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3. For suspected or confirmed MRSA infections or mixed pathogen infections (including MRSA), please list previous antibiotics trials and/or sensitivities including outcomes and dates.*
   ☐ sulfamethoxazole/trimethoprim ☐ clindamycin ☐ doxycycline or minocycline ☐ vancomycin IV
   ☐ linezolid ☐ Other _____
   Outcome/Sensitivities _____ Dates of use _____
   Outcome/Sensitivities _____ Dates of use _____
   Outcome/Sensitivities _____ Dates of use _____
   Outcome/Sensitivities _____ Dates of use _____
4. For suspected or confirmed non-MRSA mixed pathogen infections, please list previous antibiotic trials including outcomes and dates.*
   Drug _____ Outcome _____ Dates of use _____
   Drug _____ Outcome _____ Dates of use _____

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

Section XIII. Please complete for requests for Coartem > 24 units/365 days.

Please describe the medical necessity for exceeding the quantity limit.

_____

Section XIV. 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.

_____

_____

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*

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 _____