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

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.**

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 Bcise (exenatide extended-release auto-injection)
- ☐ Ozempic (semaglutide)
- ☐ Symlin (pramlintide)
- ☐ Tanzeum (albiglutide)
- ☐ Victoza (liraglutide)

Single Oral Agents

- ☐ alogliptin
- ☐ Avandia (rosiglitazone)
- ☐ Cycloset (bromocriptine 0.8 mg tablet)
- ☐ Fortamet (metformin extended-release)
- ☐ Glumetza (metformin extended-release)
- ☐ Riomet ≥ 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)

Combination Oral Agents

- ☐ Actoplus Met XR (pioglitazone/metformin extended-release)
- ☐ alogliptin/metformin
- ☐ alogliptin/pioglitazone
- ☐ Glyxambi (empagliflozin/linagliptin)
- ☐ Invokamet XR (canagliflozin/metformin extended-release)
- ☐ Jentadueto 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 _____
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.

_____

Section I. Please complete for all requests for single and combination injectable and oral agents, except metformin extended-release (generic Fortamet and Glumetza), Riomet, 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 insulin aspart (generic Novolog)?

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

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

_____

☐ No

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

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

Please describe the clinical rationale for exceeding the quantity limit. _____

_____

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.

_____

Section VII. Please complete for requests for Riomet.

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 metformin tablets.

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

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*

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 _____