



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

## Glaucoma 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

- |  |   |
|--|---|
| <input type="checkbox"/> Azopt (brinzolamide)                  | <input type="checkbox"/> timolol ophthalmic gel forming solution                  |
| <input type="checkbox"/> bimatoprost 0.03%                     | <input type="checkbox"/> Timoptic Ocudose (timolol ophthalmic unit dose solution) |
| <input type="checkbox"/> dorzolamide/timolol preservative free | <input type="checkbox"/> Vyzulta (latanoprostene)                                 |
| <input type="checkbox"/> Durysta (bimatoprost implant)         | <input type="checkbox"/> Xelpros (latanoprost emulsion)                           |
| <input type="checkbox"/> Rhopressa (netarsudil)                | <input type="checkbox"/> Zioptan (tafluprost)                                     |
| <input type="checkbox"/> Rocklatan (netarsudil/latanoprost)    |   |
| <input type="checkbox"/> Simbrinza (brinzolamide/brimonidine)  |   |

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

- Open-angle glaucoma       Ocular hypertension       Other \_\_\_\_\_

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

### Section I. Please complete for timolol ophthalmic gel forming solution and Timoptic Ocudose requests.

Has the member had a trial with an ophthalmic timolol formulation that is available without PA?  
 Yes  No. Please provide clinical rationale for not using an ophthalmic timolol formulation that is available without PA. \_\_\_\_\_

### Section II. Please complete for Azopt requests.

Has the member had a trial with dorzolamide 2%?  
 Yes  No. Please provide clinical rationale for not using dorzolamide 2%. \_\_\_\_\_

### Section III. Please complete for bimatoprost 0.03% and Durysta requests.

1. Has the member had a trial with Lumigan?  
 Yes  No. Please provide clinical rationale for not using Lumigan. \_\_\_\_\_

2. For Durysta, if you answered "No" to the question above, does the member have a medical necessity for an implantable formulation instead of eye drops?

\_\_\_\_\_

3. For Durysta, please specify affected eye.  Left eye  Right eye

4. For Durysta, is the request for retreatment of the same eye?  Yes  No

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**Section IV. Please complete for dorzolamide/timolol preservative free and Xelpros requests.**

Has the member experienced sensitivity to benzalkonium chloride or any other preservatives used in ophthalmic preparations?

Yes  No. Please provide clinical rationale for the use of the requested formulation instead of the respective formulation that is available without PA. \_\_\_\_\_

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**Section V. Please complete for Rhopressa and Rocklatan requests.**

1. Has the member had a trial of combination therapy with a prostaglandin analog and an ophthalmic beta-blocker?

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

No. Please provide clinical rationale for not using combination therapy with a prostaglandin analog and an ophthalmic beta-blocker. \_\_\_\_\_

2. Does the member have a contraindication to ophthalmic beta-blockers?

Yes. Please describe. \_\_\_\_\_  No

If yes, has the member had a trial of combination therapy with a prostaglandin analog and either an ophthalmic alpha-2 adrenergic agonist, parasympathomimetic, or carbonic anhydrase inhibitor?

Yes. Please list the drug names, dates/duration of use and outcomes below.\*  No

3. For Rhopressa, does the member have a contraindication to prostaglandin analogs?

Yes. Please describe. \_\_\_\_\_  No

If yes, has the member had a trial of combination therapy with an ophthalmic beta-blocker and either an ophthalmic alpha-2 adrenergic agonist, parasympathomimetic, or carbonic anhydrase inhibitor?

Yes. Please list the drug names, dates/duration of use and outcomes below.\*  No

4. For Rocklatan, please describe the medical necessity for use of the combination product over the separately available ingredients. \_\_\_\_\_

Please provide details for the previous trials.

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.

*\*Please attach a letter documenting additional trials as necessary.*

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**Section VI. Please complete for Simbrinza requests.**

Has the member had a trial with a carbonic anhydrase inhibitor and an ophthalmic brimonidine product?

Yes  No. Please provide clinical rationale for not using a carbonic anhydrase inhibitor and an ophthalmic brimonidine product. \_\_\_\_\_

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**Section VII. Please complete for Vyzulta requests.**

Has the member had a trial of combination therapy with latanoprost solution and an ophthalmic beta-blocker?

Yes  No. Please provide clinical rationale for not using combination therapy with latanoprost solution and an ophthalmic beta-blocker. \_\_\_\_\_  
\_\_\_\_\_

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

1. Has the member had a trial with latanoprost solution?

Yes  No. Please provide clinical rationale for not using latanoprost solution. \_\_\_\_\_  
\_\_\_\_\_

2. Has the member had a trial with Xelpros?

Yes  No. Please provide clinical rationale for not using Xelpros. \_\_\_\_\_  
\_\_\_\_\_

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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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\_\_\_\_\_

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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 \_\_\_\_\_