Harvard Pilgrim Health Care
MEDICATION PRIOR AUTHORIZATION REQUEST FORM

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional clinical data or documentation relevant to this request.

This form is being used for:		
Check one:	☐ Initial Request	☐ Continuation/Renewal Request
Reason for request *(check all that apply)*:	☐ Prior Authorization, Step Therapy, Formulary Exception ☐ Quantity Exception ☐ Specialty Drug ☐ Other *(please specify)*: _____	
Check if Expedited Review/Urgent Request:	☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)	

A. Destination	
Health Plan or Prescription Plan Name: **Harvard Pilgrim Health Care, Attn: Pharmacy Utilization Management Department**	
Health Plan Phone: **1-800-708-4414**	Fax: **1-617-673-0988**

B. Patient Information		
Patient Name:	DOB:	Gender: ☐ Male ☐ Female ☐ Unknown
Member ID #:		

C. Prescriber Information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA/xDEA:
Prescriber Point of Contact Name (POC) (if different than provider):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	
Date:	

D. Medication Information	
Medication Being Requested:	
Strength:	Quantity:
Dosing Schedule:	Length of Therapy:
Date Therapy Initiated:	
Is the patient currently being treated with the drug requested? ☐ Yes ☐ No If yes, date started:	
Dispense as Written (DAW) Specified? ☐ Yes ☐ No	
Rationale for DAW:	

E. Compound and Off Label Use	
Is Medication a Compound? ☐ Yes ☐ No	
If Medication Is a Compound, List Ingredients:	
For Compound or Off Label Use, include citation to peer reviewed literature:	

(continued on next page)

F. Patient Clinical Information

Please refer to plan-specific criteria for details related to required information.

Primary Diagnosis Related to Medication Request:

ICD Codes:

Pertinent Comorbidities:

If Relevant to This Request:

Drug Allergies:

Height: | Weight:

Pertinent Concurrent Medications:

Opioid Management Tools in Place: ☐ Risk assessment ☐ Treatment Plan ☐ Informed Consent ☐ Pain Contract ☐ Pharmacy/Prescriber Restriction

Previous Therapies Tried/Failed:

Previous Therapies

Drug Name	Strength	Dosing Schedule	Date Prescribed	Date Stopped	Description of Adverse Reaction or Failure	Check if Sample
						☐
						☐
						☐
						☐
						☐

Are there contraindications to alternative therapies? ☐ Yes ☐ No

If yes, please list details:

Were nonpharmacologic therapies tried? ☐ Yes ☐ No

If yes, provide details:

Relevant Lab Values

Lab Name and Lab Value	Date Performed	Lab Name and Lab Value	Date Performed

If renewal, has the patient shown improvement in related condition while on therapy? ☐ Yes ☐ No ☐ N/A

If yes, please describe:

Additional information pertinent to this request:

Complete this section for Professionally Administered Medications *(including Buy and Bill)*

Start Date: _____ End Date: _____

Servicing Prescriber/Facility Name: _____ ☐ Same as Prescribing Clinician

Servicing Provider/Facility Address: _____

Servicing Provider NPI/Tax ID #: _____

Name of Billing Provider: _____

Billing Provider NPI #: _____

Is this a request for reauthorization? ☐ Yes ☐ No

CPT Code: _____ # of Visits: _____ J Code: _____ # of Units: _____

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