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 M	lanagement 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 #:	Phone #:					
Specialty:	Secure Fax #:						
NPI #:	DEA/xDEA:						
Prescriber Point of Contact Name (POC) (if different than provider	·):						
POC Phone #:	POC Secure Fax #:	POC Secure Fax #:					
POC Email (not required):							
Prescribing Clinician or Authorized Representative Signature	:						
Date:							
D. Medication Information							
Medication Being Requested:							
Strength:	Quantity:	Quantity:					
Dosing Schedule:	Length of Therapy:	Length of Therapy:					
Date Therapy Initiated:							
Is the patient currently being treated with the drug requested?	Yes No If yes, date sta	arted:					
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:							

Primary Diagnosis Related to Medication Request: ICD Codes Pertinent Condes ### Contract to This Request: Drug Allingtes:	F. Patient Clinical Information								
CD Codes	*Please refer to plan-specific criteria for details related to required information.								
Pertinent Comorbidities:	Primary Diagnosis Related to Medication Request:								
Drug Name	ICD Codes:								
Drug Allergies Height	Pertinent Comorbidities:								
Height: Weight: Pertinent Concurrent Medications: Opioid Management Took in Place: Risk assessment Treatment Plan Informed Consent Pain Contract Pharmacy/Prescriber Restriction Previous Therapies Treatment Plan Informed Consent Pain Contract Pharmacy/Prescriber Restriction Previous Therapies Treatment Plan Informed Consent Pain Contract Pharmacy/Prescriber Restriction Previous Therapies Treatment Plan Informed Consent Pain Contract Pharmacy/Prescriber Restriction Previous Therapies Dute Date Date Date Date Date Date Date Check if Stopped Resection or Failure Sample Previous Prescribed Prescribed Previous Prescriber Pain Contract Pharmacy/Prescriber Restriction Pain Contract Pharmacy/Prescriber Restriction Pain Contract Pharmacy/Prescriber Restriction Pain Contract Pharmacy/Prescriber Restriction Pharmacy/Prescriber Pharmacy/Prescrib	If Relevant to This Request:								
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 Date Prescribed Stopped Reaction of Failure Sample	Drug Allergies:								
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Previous Therapies Tried/Falled: Drug Name							1 0		
Previous Therapies Drug Name	<u> </u>	ssment Ir	eatment Plan	☐ Informed (Consent LP	ain Contract Pharmacy/Pre	escriber Restriction		
Drug Name Strength Dosing Date Prescribed Stopped Reaction or Failure Sample Check if Check if Check if Check if Sample Check if Check	Previous Therapies Tried/Failed:		Previous	Theranies					
Schedule Prescribed Stopped Reaction or Failure Sample	Drug Name	Strength	1		Date	Description of Adverse	Check if		
Are there contraindications to alternative therapies? Yes No	Drug Name	Stierigtii	_						
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: Same as Prescribing Clinician Servicing Provider/Facility Name: Same as Prescribing Clinician Servicing Provider NPL/Tax ID #: Name of Billing Provider.									
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Is this a request for reauthorization?									

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.

J Code: _

of Visits: _

CPT Code: .

of Units: _