MASSACHUSETTS STANDARD FORM FOR MEDICATION PRIOR AUTHORIZATION REQUESTS

**Some plans might not accept this form for Medicare or Medicaid requests.*

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 — Where this form is being submitted to; payers making this form available on their websites may prepopulate section A	
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: _____

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