

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:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Continuation/Renewal Request
Reason for request <i>(check all that apply)</i> :	<input type="checkbox"/> Prior Authorization, Step Therapy, Formulary Exception <input type="checkbox"/> Quantity Exception <input type="checkbox"/> Specialty Drug <input type="checkbox"/> Other <i>(please specify)</i> : _____	
Check if Expedited Review/Urgent Request:	<input type="checkbox"/> (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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date started:	
Dispense as Written (DAW) Specified? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Rationale for DAW:	

E. Compound and Off Label Use	
Is Medication a Compound? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Medication Is a Compound, List Ingredients:	
For Compound or Off Label Use, include citation to peer reviewed literature:	

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
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>

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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