# NEW HAMPSHIRE UNIFORM PRIOR AUTHORIZATION FORM PRESCRIPTION DRUG REQUESTS

## A. Destination of Request *(This section is to be completed by insurers/PBMs/UREs prior to making form available)*

| | |
|---|---|
| Insurer or Pharmacy Benefit Manager (PBM) Name: **Harvard Pilgrim Health Care, Attn: Pharmacy Utilization Management** | |
| Phone #: 1-800-708-4414 | Fax #: 1-617-673-0988 |
| Electronic Prior Authorization Webpage: **https://point32health.promptpa.com** | |

***Insurers and PBMs are not permitted to require information in addition to that requested below. Certain insurers may not require all of the information requested on this form.***

## B. Type of Request

| | |
|---|---|
| Check one: ☐ Initial Request ☐ Continuation/Renewal Request | |
| Check if Expedited Review/Urgent Request: ☐ | _____ **By initialing here, I, as the treating provider, attest to the fact that this request meets the URAC (Utilization Review Accreditation Commission) health accreditation standards for urgent care** in that adherence to the standard timelines: a) could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function; or b) would subject the patient to severe pain that cannot be adequately managed without the treatment being requested. |

## C. Patient Information

| | |
|---|---|
| Patient's Full Name (including Jr, Sr, III, etc): | DOB: |
| Member ID #: | Group #: |

## D. Prescriber Information

| | |
|---|---|
| Prescribing Provider: | Phone #: |
| Address: | |
| Secure Fax #: | Specialty: |
| Prescribing Provider NPI #: | Prescribing Provider DEA #: |
| Prescriber Point of Contact (POC) Name (if different than provider): | |
| POC Phone #: | POC Secure Fax #: |
| POC Email (not required): | |
| **Prescribing Provider or Authorized Designee**<br>**Signature**: | **Date**: |

## E. Diagnosis and Medication Information

| | |
|---|---|
| Primary Diagnosis Related to Medication Request: | |
| Medication Requested: | Strength: |
| Quantity: | Dosing Schedule: |
| Length of Therapy: | Date of Prescription: |
| Is the patient currently being treated with the drug requested? ☐ Yes ☐ No If yes, date started: | |

 *(continued on next page)*

Dispense as Written (DAW) Specified? ☐ Yes ☐ No If yes, rationale for DAW:

☐ Alternate therapies contraindicated or previously tried (please provide more information in Section F)

☐ Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change (specify anticipated significant adverse clinical outcome in space below)

☐ Medical need for increase in current dosage, strength and / or frequency (specify in space below: (1) dosage, strength(s) and / or frequency(s) tried; (2) medical reason)

☐ Absence of appropriate formulation or indication of the drug (specify in space below)

☐ Other (specify in space below) Required Explanation from Above:

## F. Additional Clinical Information (provide as relevant to the request)

Drug Allergies:

| Height: | Weight: |
|---|---|

Relevant Lab Values/Test Results (Providers may attach additional pages or documentation as needed)

| Lab/Test Name and Results | Date | Lab/Test Name and Results | Date |
|---|---|---|---|
| | | | |
| | | | |

Previous Medications and/or Non-Pharmacologic Therapies Tried/Failed
(Providers may attach additional pages or documentation as needed)

| Medication/Therapy Name | Strength (as relevant) | Dosing Schedule (as relevant) | Date Prescribed/ Started | Date Stopped | Description of Adverse Reaction or Failure |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

List any contraindications to alternate therapies (Providers may attach additional pages or documentation as needed)

| Therapy | Description of Contraindication |
|---|---|
| | |
| | |

Additional information (prescribing providers may provide additional information to support this request):

(Providers may attach additional pages or documentation as needed)

## G. Confidentiality Notice



***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 or documentation relevant to this request.***