MASSACHUSETTS STANDARD FORM FOR MEDICATION PRIOR AUTHORIZATION 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:

Health Plan Phone: Fax:

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:

Pertinent Concurrent Medications:

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

Previous Therapies Tried/Failed:

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Strength</th>
<th>Dosing Schedule</th>
<th>Date Prescribed</th>
<th>Date Stopped</th>
<th>Description of Adverse Reaction or Failure</th>
<th>Check if Sample</th>
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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

<table>
<thead>
<tr>
<th>Lab Name and Lab Value</th>
<th>Date Performed</th>
<th>Lab Name and Lab Value</th>
<th>Date Performed</th>
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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:

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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.*