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:

- 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: Mass General Brigham Health Plan

Specialty Medication PA Request Phone: (866) 814-5506
Nonspecialty Medication PA Request Phone: (877) 433-7643 (Medicaid), (855) 582-2022 (Exchange), (800) 294-5979 (Commercial)

Specialty Medication PA Request Fax: (866) 249-6155
Nonspecialty Medication PA Request Fax: (866) 255-7569 (Medicaid), (855) 245-2134 (Exchange), (888) 836-0730 (Commercial)

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:
### 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:

<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>
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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: ___________________________
- 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 healthplan’s coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.*