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 prepulate 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  Online Prior Authorization: https://point32health.promtpa.com

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:

<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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.