# Massachusetts Standard Form for Medication Prior Authorization Requests

*Some plans might not accept this form for Medicare or Medicaid requests.*

<table>
<thead>
<tr>
<th>This form is being used for:</th>
<th>☐ Initial Request</th>
<th>☐ Continuation/Renewal Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for request (check all that apply):</td>
<td>☐ Prior Authorization, Step Therapy, Formulary Exception</td>
<td>☐ Quantity Exception</td>
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<td></td>
<td>☐ Specialty Drug</td>
<td>☐ Other (please specify):</td>
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<tr>
<td>Check if Expedited Review/Urgent Request:</td>
<td>☐ (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.)</td>
<td></td>
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</table>

## 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:** OptumRx on behalf of Harvard Pilgrim Health Care
- **Health Plan Phone:** 1-855-258-1561
- **Fax:** 1-844-403-1029

## 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>
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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:

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: ___________________________  
- J Code: ___________________________  
- # of Visits: ___________________________  
- # 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.