

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:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Continuation/Renewal Request
Reason for request (<i>check all that apply</i>):	<input type="checkbox"/> Prior Authorization, Step Therapy, Formulary Exception <input type="checkbox"/> Quantity Exception <input type="checkbox"/> Specialty Drug <input type="checkbox"/> Other (<i>please specify</i>): _____	
Check if Expedited Review/Urgent Request:	<input type="checkbox"/> (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:	WithMe Health	
Health Plan Phone: 1-866-840-1877	Fax:	1-866-678-8301

B. Patient Information		
Patient Name:	DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date started:	
Dispense as Written (DAW) Specified? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Rationale for DAW:	

E. Compound and Off Label Use	
Is Medication a Compound? <input type="checkbox"/> Yes <input type="checkbox"/> 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:						
<i>If Relevant to This Request:</i>						
Drug Allergies:						
Height:				Weight:		
Pertinent Concurrent Medications:						
Opioid Management Tools in Place: <input type="checkbox"/> Risk assessment <input type="checkbox"/> Treatment Plan <input type="checkbox"/> Informed Consent <input type="checkbox"/> Pain Contract <input type="checkbox"/> Pharmacy/Prescriber Restriction						
Previous Therapies Tried/Failed:						
Previous Therapies						
Drug Name	Strength	Dosing Schedule	Date Prescribed	Date Stopped	Description of Adverse Reaction or Failure	Check if Sample
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
Are there contraindications to alternative therapies? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If yes, please list details:						
Were nonpharmacologic therapies tried? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If yes, provide details:						
Relevant Lab Values						
Lab Name and Lab Value	Date Performed	Lab Name and Lab Value	Date Performed			
If renewal, has the patient shown improvement in related condition while on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: _____ <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.