

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: AllWays Health Partners	
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: <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						
<i>*Please refer to plan-specific criteria for details related to required information.</i>						
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 healthplans coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.