### This form is being used for:

- [ ] Initial Request
- [x] 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:** AllWays Health Partners

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

**Specialty Medication PA Request Fax:** (866) 249-6155  
**Non specialty 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/#DEA:**

**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  
- [x] 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>
<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: ____________________________ # 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.*

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Massachusetts Collaborative — Massachusetts Standard Form for Medication Prior Authorization Requests

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