**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>
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<tbody>
<tr>
<td>Check one:</td>
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<tr>
<th>Reason for request (check all that apply):</th>
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<tbody>
<tr>
<td>☐ Prior Authorization, Step Therapy, Formulary Exception</td>
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<tr>
<td>☐ Quantity Exception</td>
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<tr>
<td>☐ Specialty Drug</td>
</tr>
<tr>
<td>☐ Other (please specify):</td>
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<tr>
<th>Check if Expedited Review/Urgent Request:</th>
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<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>
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**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

**Medical Specialty Medication PA Request Phone:** (844) 345-2803  
**Medical Specialty Medication PA Request Fax:** (844) 851-0882

**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:
**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>
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<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:

<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:

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**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.*